

Political Economy of Health and the Financing of Contemporary Universal Health Systems in the Light of Paul Singer's Thought

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Abstract

Universal health systems are susceptible to the structural crises of capitalism and have had to adapt to the sudden social changes in the neoliberal scenario, with commodification, drastic cuts in resources and changes in financing schemes. The discussion on the sustainability of systems has required that the economic instrument be increasingly considered, which requires the use of the theoretical framework of political economy and a critique of the predominant neoclassical narrative. The study aims to identify, through a systematic review of the literature, the production on the theme of financing systems in the context of the political economy of health in the light of the contribution of the Austro-Brazilian economist Paul Singer, in the work "Prevenir e Curar: o Controle Social Através dos Serviços de Saúde" (Singer et al., 1978). Of the 47 articles included in the Review, only 33.6% promote discussions focused on political economy; of these, 76.6% are aligned with Keynesian thought and 23.4% with the Marxist view. There is convergence in relation to the dimensions discussed by Singer: historical perspective (91.5%), health systems under the aegis of the capitalist State (100%), social control (23.4%), health status (57.4%) and evaluation criteria (72.3%). The identified studies and Singer's thinking converge in identifying the limitation of *Economics* in the face of the insertion of the health issue within the scope of the interests that make up capitalist society.

Keywords

Health Systems, Health Systems Financing, Health Economics, Review

1. Introduction

In contemporary capitalism, universal health systems are susceptible to the structural

crises of this mode of production and its turbulence. Thus, they have had to adapt to sudden social changes, especially in the neoliberal global scenario (Mendes, 2015). The implications of capitalism under the dominance of financial capital for social policies are evident through restrictive economic policies that impact public financing and compromise the sustainability of these systems and the guarantee of health as a social right. Resources and the political and social environment are disputed in the movement of contemporary capital, under the predominance of interest-bearing capital, in its most perverse form, fictitious capital (Ferreira & Mendes, 2018; Mendes & Carnut, 2018).

The challenges of financing universal health systems have required that economic instruments be increasingly taken into account in the area of public health to understand the new characteristics and limits of financing schemes (Mendes, 2022). However, its use has been more restricted to topics that deal with insufficient resources, inefficiency and ineffectiveness, with an emphasis on the mathematization of the economic, typical of the neoclassical economic approach (Braga & Paula, 1981). Without a persistent critique of the prevailing narrative, the understanding of health as a right is now under threat (Carnut et al., 2021). It is necessary to shed light on the relationship between the financing of universal systems and the elements inherent to capitalism, discussed by authors in political economy, and especially in the field of health.

Among these authors, we highlight an excerpt from Paul Singer's thought (1932-2018), an important Austro-Brazilian economist, on the evaluation of health services (HS), their nature and particularities in capitalist society. The referenced work is the book "Preventing and Healing: Social Control through Health Services", from 1978, in which Singer presented the results of the research carried out with Oswaldo Campos and Elizabeth de Oliveira. Singer et al. (1978) discuss the insertion of the HS in capitalist societies based on some dimensions: they are historically evolved services; they were fully institutionalized with the creation of universal health systems formulated within the capitalist State; they are part of the scope of social control, in order to identify, prevent, cure and manipulate morbid states; and they contribute to the health status of the population, posing the methodological problem of evaluating them.

The critique by Singer et al. (1978), contextualized in the development of productive forces, capitalism in general and the health sector in particular, is essential to understanding the contradiction between the expansion of medical practice and the ineffectiveness of medicine in resolving, by itself, the population's health problems. This problem leads to the expansion of control mechanisms and economic analyses of health policies. Questions also arise regarding the institutionalization of the HS, the expansion of the consumption of services and technologies and the growing costs of health care.

It is important to emphasize that the work of Singer et al. (1978) emphasizes health services to the detriment of health systems, which are rarely mentioned in this work. The authors operationally delimit the HS studied by the explicit

purpose of preserving or restoring health, excluding services that meet demands other than health, even if their activities reflect on it. It is emphasized that the full institutionalization of the HS, in order to reach the entire population, is a process that was only completed in developed capitalist countries after the last World War (Singer et al., 1978: p. 34), as an integral part, and one of the most visible, of the modern Welfare State (Singer et al., 1978: p. 37), which coincides with the creation of national health services and the strong expansion of social insurance for society as a whole, in a full employment situation. In this movement, there is a need for some kind of socialization of medical care, making it accessible to the entire population, revealing universality as a dimension of the institutionalization of health care (Singer et al., 1978: p. 37).

As an instrument of social control, it is worth noting that the HS guarantee the re-production of the social structure by ensuring the perpetuation of living conditions and capitalist relations. Once these relations between the health field and other social practices are understood, the neutrality of the health sciences and the analyses anchored in this assumption are questioned, which, sometimes, do not make intentions explicit. Taking financing and resource allocation as the means for the functioning of the HS and for the implementation of health as a social right, the aim here is to investigate to what extent the issues raised by Singer et al. (1978) are present in the contemporary discussion about the sustainability and financing of universal health systems. Thus, for the purposes of this study, we have chosen to divide the contribution of this work into five dimensions that will articulate the discussion of the results of the systematized review: a) social control; b) historical perspective; c) health system; d) health status; and e) evaluation of health services.

Next, we sought to identify, through a systematized review, the existing economic thinking in international scientific production dedicated to the study of universal health systems with a focus on their financing and the contribution of political economy in its relationship with these dimensions of Singer et al. (1978) in the context of the current clashes over the financing of health systems.

2. Methodology

2.1. Objective

The integrative review of the literature which addresses the financing of health systems aims to construct a synthesis of the production of the political economy of health on this topic, in its relationship with the dimensions of Singer et al. (1978). To define the descriptors, the following research question was defined: “To what extent is the theoretical framework of political economy, in light of Paul Singer’s perspective, present in health economics studies that address the issue of health financing in universal systems in the contemporary phase of capitalism?”.

2.2. Data Sources and Search Strategies

The repositories searched were: BVS (Lilacs/Scielo), MEDLINE (PubMed),

SCOPUS and Web of Science. The phenomenon was “health financing” and the population was “universal health systems”. The context refers to health economics. To formulate the syntaxes, we considered the terms referring to the countries that have public health systems: France and Germany (Bismarckian type); the United Kingdom, Portugal, Spain, Italy, Brazil, Canada, France, Sweden and Costa Rica (Beveridgian type); and Cuba (state monopoly). From the syntaxes, carried out in January 2024, a total of 3412 studies were identified that could answer the review question (**Table 1**).

Table 1. Syntaxes and number of studies identified in scientific repositories.

Repositories	Syntaxes	Number of studies identified
BVS	((mh:(“financiamento dos sistemas de saude” OR “financiamento da assistencia a saude” OR “financiamento governamental” OR “recursos em saude” OR “recursos financeiros em saude” OR “gastos em saude”)) AND (mh:(“sistemas de saude” OR “sistemas nacionais de saude” OR “medicina estatal” OR “politica de saude” OR “servicos de saude” OR “sistemas publicos de saude”)) AND (“Inglaterra” OR “Escocia” OR “Pais de Gales” OR “Irlanda do Norte” OR “Portugal” OR “Espanha” OR “Franca” OR “Italia” OR “Alemanha” OR “Suecia” OR “Brasil” OR “Cuba” OR “Costa Rica” OR “Canada”).	1772
MEDLINE (PubMed)	((Healthcare Financing[MeSH Terms])) OR ((Financing, Organized[MeSH Terms])) OR ((Financing, Government[MeSH Terms])) OR ((Health Planning Support[MeSH Terms])) AND ((((((Universal Health Care[MeSH Terms])) OR ((Delivery of Health Care[MeSH Terms])) OR ((Delivery of Health Care, Integrated[MeSH Terms])) OR (State Medicine[MeSH Terms])) OR (Patient Acceptance of Health Care[MeSH Terms])) AND (“England” OR “Scotland” OR “Wales” OR “Northern Ireland” OR “Portugal” OR “Spain” OR “France” OR “Italy” OR “Germany” OR “Sweden” OR “Brazil” OR “Cuba” OR “Costa Rica” OR “Canada”) AND (“health system\$”).	605
SCOPUS	TITLE-ABS-KEY (financing) AND TITLE-ABS-KEY (“Universal Health Care”) OR TITLE-ABS-KEY (“health system*”) AND TITLE-ABS-KEY (England) OR TITLE-ABS-KEY (Scotland) OR TITLE-ABS-KEY (Wales) OR TITLE-ABS-KEY (Northern Ireland) OR TITLE-ABS-KEY (Portugal) OR TITLE-ABS-KEY (Spain) OR TITLE-ABS-KEY (France) OR TITLE-ABS-KEY (Italy) OR TITLE-ABS-KEY (Germany) OR TITLE-ABS-KEY (Sweden) OR TITLE-ABS-KEY (Brazil) OR TITLE-ABS-KEY (Cuba) OR TITLE-ABS-KEY (Costa Rica) OR TITLE-ABS-KEY (Canada).	653
Web of Science	((TS = (financing)) AND TS = (“universal health care” OR “state medicine” OR “Delivery of Health Care” OR “health system*”) AND TS = (England OR Scotland OR Wales OR “Northern Ireland” OR Portugal OR Spain OR France OR Italy OR Germany OR Sweden OR Brazil OR Cuba OR “Costa Rica” OR Canada).	382
Total studies identified		3412

Source: Elaborated by the authors.

Figure 1 describes the literature selection process in a PRISMA flowchart. All results were exported and cataloged in the Zotero software, which excluded 561 studies due to duplication, 122 studies prior to 1980 (outside the contemporary phase of capitalism), 196 studies in languages other than Portuguese, English and Spanish and 443 studies that were not scientific articles. A total of 2090 studies were obtained.

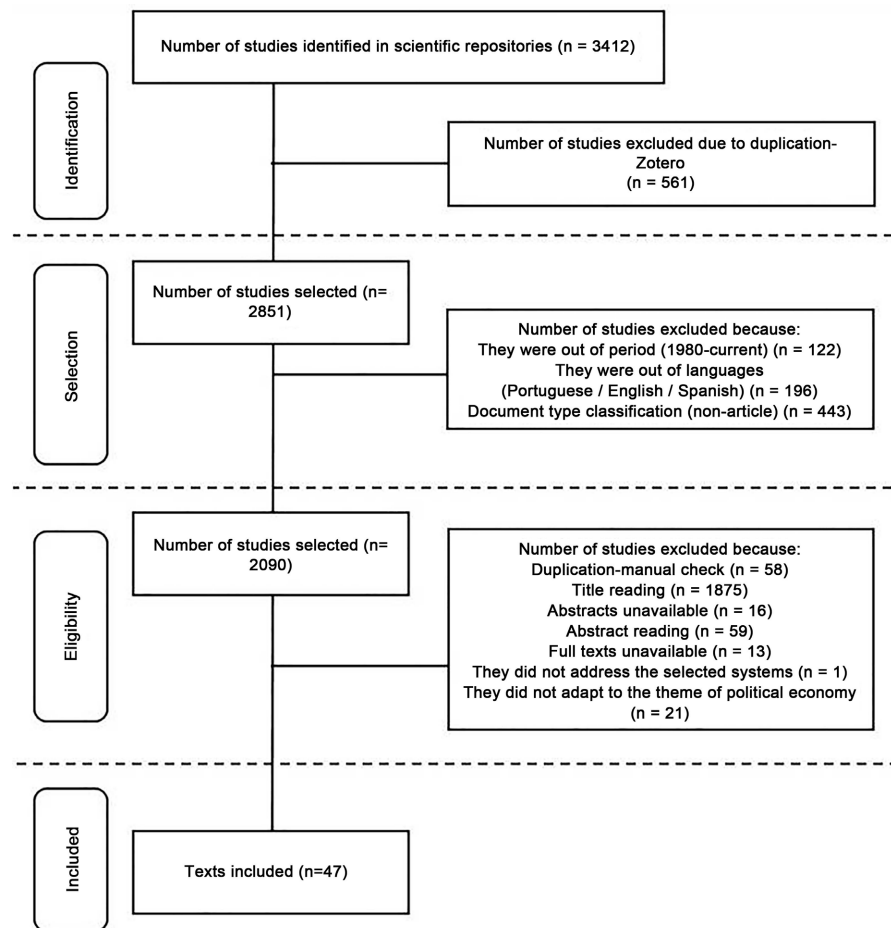


Figure 1. Number of studies identified in the scientific repositories consulted.

The manual check of the results sequentially excluded another 58 duplicate studies, 1875 off-topic studies (with no direct mention of the topic in the title or through terms or concepts similar to: financing, public spending, allocation, crisis, reform, austerity or sustainability), 16 studies with no abstracts available. A total of 141 studies discussing financing were obtained.

During the abstract reading stage, 59 articles were excluded, which did not mention financing or allocation of financial resources, which discussed other countries and which primarily addressed management strategies, efficiency, models and econometric analysis. Of the remaining 82 articles, 13 articles were excluded because they did not have full texts available and 1 article that addressed

the system of a country not studied. Thus, 68 articles were selected for mapping economic thought, of which 21 studies reflected neoclassical thought or did not promote discussion within the scope of political economy and were excluded. Therefore, 47 studies were selected for analysis, considered as articles included in this review.

2.3. Analysis of Results

First, it is worth highlighting the proportion of the 47 articles included from the perspective of political economy in relation to the total of 140 articles that discuss the financing of the systems of countries that were the subject of this review (the stage in which 141 abstracts were included was considered, excluding 1 article that discussed the system of a country that was not studied), which allows us to assess the extent to which this approach is present in literature. It was found that at least 80 studies (59 excluded in the abstract reading stage and 21 excluded in the full-text reading stage) do not discuss financing from the perspective of political economy. The other 13 studies do not have full text available and, therefore, were not included in any category.

Taking into account the universe of articles with available abstracts, the systematic literature review reveals that 33.6% of the partial results discuss political economy ($n = 47$), while 57.1% do not ($n = 80$) and that there is an uncertainty of 9.3% regarding articles without full text ($n = 13$).

Regarding the predominant economic thinking in political economy articles, 76.6% of the studies ($n = 36$) are closer to the Keynesian perspective, while 23.4% ($n = 11$) resort to the Marxist perspective. This categorization is not exhaustive and takes into account the greater proximity of the Marxist critical perspective to capitalist society, reflected in the crisis of capital and the limited role of the State in health policies, or of Keynesian thinking, emphasizing the regulatory role of the State and the reduction of social inequalities. Thus, even authors who are not traditionally classified as Marxists or Keynesians may appear in one or the other field according to the specific content of the reviewed article.

In relation to the health systems covered, studies on the Brazilian Unified Health System (SUS) predominate ($n = 34$), representing 72.3% of the articles; followed by Spain ($n = 7$); United Kingdom, Canada and Sweden ($n = 2$); and Portugal, Germany, Cuba and Costa Rica ($n = 1$). No article addresses France or Italy. It can also be said that the concentration on studies that comment on the universal health systems of Brazil and Spain is justified by the fact that these systems were instituted more recently than the others, that is, in the 1980s, precisely in the context of the adoption of neoliberal reforms.

Table 2 presents the thematic axes and main topics of each article, together with the number of results.

Table 3 presents the 47 articles included in the review, according to author, year of publication, theme, context, predominant economic thought, discussion and main conclusions regarding the political economy of health.

Table 2. Number of articles included by axes and topics.

Axis and topics	Number of articles
AXIS 1: UNIVERSAL SYSTEMS AND CAPITALISM	6
Contradictions of the health system in capitalism	2
Capital crisis and health	1
Political economy	1
Financialization and health	2
AXIS 2: CRISIS AND AUSTERITY	8
Austerity policies in Europe	4
Austerity policies in Brazil	3
Economic crises	1
AXIS 3: SYSTEMS REFORMS	5
PHC reform	3
Systems reform	2
AXIS 4: HEALTH POLICIES AND THE FINANCING OF PHC	6
World Bank and health systems	1
Pharmaceutical coverage	1
Social policies and health	1
Sustainable development agenda	1
PHC financing	2
AXIS 5: DECENTRALIZATION	5
Decentralization	5
AXIS 6: PUBLIC EXPENDITURE	5
Contingency	1
National expenditure	1
Subnational expenditure	3
AXIS 7: PUBLIC-PRIVATE RELATIONSHIP	4
Public-private mix	2
Tax waiver	2
AXIS 8: RESOURCE ALLOCATION	3
Parliamentary amendments	1
Allocative methodology	2
AXIS 9: FINANCING SOURCES	2
Progressive financing	1
New financing sources	1
AXIS 10: FINANCING NEEDS	3
Projection of financing needs	2
Ageing and the right to health	1
Total studies	47

Source: Elaborated by the authors.

Table 3. Summary of the articles included.

Author, year and topic	Context and predominant thinking	Discussion	Main contributions
AXIS 1: UNIVERSAL SYSTEMS AND CAPITALISM			
Alves et al., 2019 Political economy and health.	Brazil, academic production in health economics Marxist	Mapping the production of health economics, highlighting the relevance of political economy in the context of the sustainability of the Unified Health System (SUS).	Preponderance of production in “health management” and “cost-effectiveness analysis” suggests that researchers are mostly aligned with neoclassical thinking. Of the 254 PHDs considered to be “health economists”, only 11.0% (28) produce on “political economy”.
Mendes & Carnut, 2018 Capital crisis and health.	Brazil, contemporary capitalism under the dominance of interest-bearing capital Marxist	Analysis of the capitalist crisis, discussion of the political form and the effects of the crisis on the problem of health underfunding and the private appropriation of public policies.	The capitalist crisis is associated with the downward trend in the rate of profit, and the dominance of interest-bearing capital is at the center of economic and social relations. The State has become an essential element of capitalist relations of production, in a context of private appropriation of the system through managerialism.
Sestelo, 2018 Financialization and health.	Political action of capital in process, with particular emphasis on Marxist Brazil	Reconstitution of the trajectory of capital in health care. Discussion on financial dominance.	Different transaction spaces have been incorporated into the process of sectoral capitalist accumulation, transforming health care into a privileged locus for capital in the process. Financialization involves large productive corporations and the state’s regulatory bodies.
Costa, 2017 Contradictions of the health system in capitalism.	Brazil, private dominance in the health system Marxist	Discussion of the hypothesis that the health sector in Brazil operates under private dominance. Description of the organizational arrangement to reflect on austerity.	Interests with greater vocalization capacity have been successful in imposing their preferences on the configuration of the sector. Brazil’s public spending on health is not very expressive, and is singular when compared to emerging countries. Participation of private insurance and direct disbursement compromises equity.
Machado et al., 2017 Contradictions of the health system in capitalism.	Brazil, health policy between 1990 and 2016 Marxist	Brazilian management of health policy, according to three axes: national context, political process and policy content (priorities and strategies).	Expansion of services concomitantly with the strengthening of the private sector. Problems with the tax sharing system have compromised the greater impact of allocations to poorer regions. Excessive conditionalities compromise autonomy.

Continued

Mendes & Marques, 2009 Financialization and health.	Brazil, macroeconomic policy in the 1990s and 2000s Marxist	Reconstitution of the institutionalization of SUS financing. Identification of tensions and conditionalities.	The financing crisis was made clear by the adoption of a restrictive macroeconomic policy, attempts to reduce spending and difficulties in implementing the principles of the SUS. A project of economic and social development was defended, breaking with the adopted economic policy focused on financial capital.
AXIS 2: CRISIS AND AUSTERITY			
Borges et al., 2018 European fiscal adjustment	Spain, spending control after the 2008 crisis. Marxist	Analysis of the fiscal adjustments adopted in response to the 2008 financial crisis, their implications for the health system and citizen resistance.	Austerity measures have imposed budget limitations, reduced services, introduced co-payments and set back the right to health from meritocracy. The purpose of the economic adjustments is the regressive transfer of income and wealth. Alternative of political resistance to the dismantling of the system.
Massuda et al., 2018 Brazilian fiscal adjustment	Brazil, from 2000 to the economic crisis that began in 2015. Keynesian	Literature review, policy analysis and government data to examine changes in the political and economic context, financing and coverage of the HS.	There have been improvements in the health of the population, but there are still structural problems in management, underfunding and resource allocation. Great regional disparities. Economic and political crises, combined with austerity, pose great risks and require resilient health systems.
Santos & Vieira, 2018 Brazilian fiscal adjustment	Brazil, the right to health and fiscal austerity in international perspective. Keynesian	Analysis of the effects of austerity from an international perspective. Discussion of the measures implemented in Brazil and their likely impact on social protection.	Brazilian austerity does not affect all of society equally, nor does it have temporary effects. Its aim is to promote a reduction in the size of the state. Paths of social and economic development imply overcoming the historical characteristics of social and economic formation.
de Souza, 2017 Brazilian fiscal adjustment	Brazil, implications of CA No. 95/2016. Keynesian	Historical description and presentation of evidence of the harmful effects of austerity, in light of measures to reduce health spending.	Evidence suggests that fiscal austerity, economic shock and the fragility of social protection interact to increasing health and social crises. And inequalities. The objective of maintaining the payment of public debt is evident.

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Cantero Martínez, 2016 European fiscal adjustment	Spain, reforms resulting from the economic crisis. Keynesian	Analysis of the most important changes affecting the essential characteristics of the public service and the legal status of users.	The reforms aim to make the health system more efficient and economically sustainable. However, they have produced an important “mutation” of the public service, which has affected its basic inspiring principles, the insurance model, its universality, its financing and, with it, the principles of equity and cohesion of the system.
Lehto et al., 2015 Economic crises	Nordic countries, economic crises since the late 1980s Keynesian	Discussion of the main institutional and political changes in systems related to macroeconomic crises.	There is a possible link with ideological, political and cultural changes, such as neoliberalism and the decline in support for socialists and social democrats. Changes in the health system do not follow the rhythm of macroeconomic cycles. These have become reference points for adjustments aimed at controlling spending and productivity.
Giovanella & Stegmüller, 2014 European fiscal adjustment	Germany, the United Kingdom and Spain, health reforms resulting from the 2008 economic crisis. Keynesian	Analysis of the repercussions in three dimensions of universality: breadth of coverage; scope of the basket of services; level of coverage by public financing.	Universality is affected with different intensity in the countries and the deepening of regulated competition and co-marketing policies. There have been no major changes to the benefits package and reductions in coverage have been marginal. Persistent stagnation or reductions in public spending could have deleterious consequences.
Segura Benedicto, 2014 European fiscal adjustment	Spain, reforms resulting from the economic crisis. Keynesian	Characterization of the crisis and its effects, evaluation of the evolution of health spending and discussion on policy reorientation.	The meaning of “austerity”, which is to do without the superfluous, has been expropriated, with practical repercussions in the reduction of public spending on health. The consequences depend on the ability to adapt to the new circumstances. Viable alternatives must be defended, such as community health promotion and intersectoral policies.

 AXIS 3: SYSTEMS REFORMS

Seta et al., 2021 PHC Reform.	Brazil, changes in the financing of the PHC. Keynesian	Discussion about the changes imposed by the Previne Brasil Program, identification of contradictions and alternatives.	There is a need to criticize the design of the program. Alternative proposals that are negotiated must emphasize that registering users cannot condition access and regular budget transfers. The fixed PCF needs to be maintained, in a non-negotiable way, due to its structuring nature.
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Massuda, 2020 PHC Reform.	Brazil, changes in the financing of the PHC. Keynesian	Analysis of global trends in financing and remuneration for services, as well as advances, challenges and threats to PHC and the SUS.	SUS has made substantial progress towards Universal Health Coverage. Despite the modernizing veneer, the new policy should limit universality, increase distortions in funding and induce the targeting of PHC actions, contributing to the reversal of historic achievements.
Morosini et al., 2020 PHC Reform.	Brazil, Reorganization of primary care between 2019 and 2020. Marxist	The aim is to understand how the projected changes in management functions and in the healthcare model contribute to strengthening the market logic.	The changes in the allocation of resources, the relationship with the private sector and the adaptation of the model to the particularities of the market reveal a privatizing direction. An individualized approach to the care and funding model, weakening the territorial perspective, community work and comprehensive, multidisciplinary care.
Atun et al., 2015 Systems reform.	Latin America, health system reforms from the end of the 1980s. Keynesian	Discussion of how demographic, epidemiological, economic, political and socio-cultural factors have pushed countries to strengthen their systems.	Distinct approaches to system reforms have been developed, combining changes in demand and comprehensive primary health care. Reforms promoted inclusion, citizenship and health equity, pushing them to achieve universal health coverage.
Diderichsen, 1995 Systems reform.	Sweden, Swedish health care reform in the 1990s. Keynesian	Discussing the extent to which the reforms are a planned market solution or a threat to the basic principles of the welfare state.	Reforms have focused on the purchaser-provider split and fee-for-service. Increased efficiency threatens fairness in some respects. Fee-for-service means an increase in production and, so far, an increase in costs, which if met with greater private funding will bring the risk of inequalities.
AXIS 4: HEALTH POLICIES AND THE FINANCING OF PHC			
Kershaw, 2020 Social policies and health.	Canada, investments in the social determinants of health since 1976. Keynesian	Analysis of how investments in social determinants of health, by age group, evolved in relation to investments in HS.	There was greater alignment between the concept of "Health in All Policies" (HiAP) and public finances for older people than for younger people. The results will help in the future evaluation of public investments in health and beyond.

Continued

Vieira, 2020 Health financing and the World Bank	Brazil, health financing in the 2030 Agenda. Keynesian	Assessment of financing and trends in the allocation of federal resources in large areas and the possibility of achieving health-related goals in the 2030 Agenda.	Achieving the goals depends on increasing public funding for health and other social policies. If the current situation does not change, with policy priorities being redefined, the risk of non-compliance is very high.
Chowdhury & Chowdhury, 2018 Pharmaceutical coverage.	Canada, drug coverage in the health system Keynesian	Discussion of the health system with emphasis on the lack of universal coverage for medicines.	The lack of universal drug coverage creates variations between provinces and health inequalities. The Health Act does not provide a formal definition of medical necessity. It is necessary to introduce this, as well as a policy on access to medicines.
Mendes et al., 2018 PHC financing.	Brazil, federal funding of primary healthcare. Marxist	Discussion of the historical trajectory of the concept of Primary Care (PC), history of federal funding transfers with emphasis on this level of care.	It is necessary to refer to the radical critical reflection of the concept of PC, related to primary health care and to confronting the social determination of health. SUS was created based on the principality of AP and this must have financing compatible with its expanded conceptual expression.
Rizzotto & Campos, 2016 World Bank and health systems.	Brazil, relationship with the World Bank in health policies. Marxist	Discussion of the role played by the World Bank, identifying continuities and changes in the way the institution acts.	There has been a shift in the World Bank's actions from the national to the state and municipal spheres. The Brazilian federative model and the health system make it possible to implement decentralized management mechanisms that could change the configuration of the SUS.
Castro & Machado, 2010 PHC financing.	SUS, financing and regulation of APS from 2003 to 2008. Keynesian	Analysis of the federal management of PHC policy.	Federal funding remains fragmented, aimed at inducing specific programs, limiting the decision-making of local managers. Combating regional inequalities would imply a greater allocation of resources and more substantial changes in federal funding.

 AXIS 5: DECENTRALIZATION

De Paiva et al., 2017 Decentralization.	Brazil, problem of federative coordination. Keynesian	Theoretical review on establishing the "right" level of distribution of competences, powers and resources.	Conditional transfers were linked to other powers of regulation. The greater the decentralization, the greater the inequality in planning, operationalization and spending capacity, and the greater the importance of equalization and the establishment of national standards.
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Vazquez, 2011 Decentralization.	Brazil, new rules and incentives for the expansion of government resources. Keynesian	Analysis of the institutional and federative aspects of federal regulations on health policy. Evaluation of the results obtained by the rules and incentives.	The linking of revenues and the standardization of conditional federal transfers resulted in an increase in total spending, accompanied by a reduction in horizontal inequalities in the resources applied by municipalities in health financing.
Costa-Font & Gil, 2009 Decentralization.	Spain, regional organization of the health system. Keynesian	Discussion of the association between inequalities, access and funding, evaluating the different levels of attribution of responsibilities of regional systems.	Inequalities in health seem to be driven by inequalities in income and in the use of services. The states in the regions politically responsible for the organization of health did not show significant differences in health and health inequalities and tend to have better equity performance.
Lima, 2007 Decentralization.	Brazil, fiscal federalism and health financing. Keynesian	Survey and discussion of the main characteristics, changes that have occurred, existing relationships and their developments.	The rules that guide resource transfers have a limited effect on fiscal redistribution and reducing inequalities in health revenues. For the most part, they are strongly related to the profile of installed capacity and the historical series of spending.
Puig-Junoy & Rovira, 2004 Decentralization.	Spain, from 1996 to 2002, under the conservative government. Keynesian	Description of issues related to the impact of tax reforms and regional decentralization of financing.	The reform of the tax treatment of private insurance presents important efficiency and equity issues that make it questionable. There is still a lack of transparent and more evidence-based equity criteria to judge the regional allocation of resources.

 AXIS 6: PUBLIC EXPENDITURE

Crozatti et al., 2020 Expenditure by sub-national entities.	Brazil, municipal spending between 2003 and 2018. Keynesian	Identification and description of the sources of funding and the expenditure committed, description by population size and geographical region.	The highest per capita values are in the Southeast and South regions; the lowest in the Northeast and North. The main source of funds is their own revenue. Transfers from the Federal Government exclusively for health are the second largest source of these resources. Municipalities in the Northeast and North are more dependent on federal resources.
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Vieira & Santos, 2018 Contingency	Brazil, expenditure cuts between 2002 and 2015. Keynesian	Discussion of the budgetary and financial execution of expenditure on federal government actions and services.	The authorized payment limit was insufficient to cover all expenses, leading to a high number of registrations recorded as pending payment. The cancellation of part of these had an impact on the use of resources, aggravating the SUS financing problem. Potential for “institutional default”.
Costa et al., 2015 Expenditure by sub-national entities.	Brazil, state expenditure and share of financing between 2002 and 2013. Keynesian	Analysis of state public spending on health and the participation of states and the Federal District in financing the SUS.	Disparity in terms of investment by the Federation. Although municipalities and states have gradually increased their spending on health, the federal government has maintained the same budget. These results reveal concern about the financing of public health.
Machado et al., 2014 National expenditure.	Brazil, federal health financing in the 2000s. Keynesian	Analysis of changes in federal participation in health financing.	Federal spending is pressured by factors such as instability in sources, high private spending and limited and erratic investments. The challenges are to consolidate stable sources, restrict subsidies, expand public participation, target strategic areas and reduce inequalities.
Campelli & Calvo, 2007 Expenditure by sub-national entities.	Brazil, compliance with Constitutional Amendment 29 between 2000 and 2003. Keynesian	Verification of compliance with CA-29 by federal entities.	Health stopped receiving R\$7.09 billion from the Union and the states. The average application of municipal resources was increased. More responsibilities and financial contributions from states and municipalities. Prioritization is based on political will, given the proven need for more resources.

 AXIS 7: PUBLIC-PRIVATE RELATIONSHIP

Ocké-Reis, 2018 Tax waiver.	Brazil, tax revenue waiver for health between 2003 and 2015. Marxist	Estimation of federal tax expenditures on health and discussion in the light of political economy and public finance.	The amount was not insignificant, resulting in R\$331.5 billion in revenue being lost. It is suggested that these resources could be better used. In the context of the underfunding of the SUS, consideration should be given to the nature of the regulation of tax expenditures on health.
Bahia, 2008 Public-private mix	Brazil, transfer of public resources to private health plans and insurance. Keynesian	Discussion about the trends in the scenario of relations between the public and the private and the effects of segmentation of demands, naturalization of inequities in access to HS.	Evidence points to a vector of privatization of the SUS, with “extirpation” of the meaning of the original project of the right to health. Not only the amount of public resources but also the way in which they are circulated reinforces an expensive, fragmented and ineffective healthcare model.

Continued

Andreazzi & Ocké-Reis, 2007 Tax waiver.	Brazil, exemption from health tax collection in income tax. Keynesian	Investigation of various aspects related to government incentives for health financing, discussion in the light of equity, with the identification of conflicts of interest.	A policy that restricts waivers would have a questionable effect on the inequity of funding, as there would be no guarantee that these resources would be used for health. Other federal resources could be reallocated to health care for the poorest, given the resources earmarked for paying off the stock and financial charges of the public debt.
Bahia, 2005 Public-private mix	Brazil, impacts of patterns and changes in financing and regulation on public-private relations. Keynesian	Discussion on the use of public sources, demand and supply of plans, customer flow and installed capacity created and reproduced with public resources.	Deep inequalities, regional asymmetries and the persistence of the privatized features on which the system was built were permanent obstacles. Tensions arise from the hybrid forms of provision and organization of service networks. Interests, conflicts and consensus are constantly renewed.
AXIS 8: RESOURCE ALLOCATION			
Barr et al., 2014 Allocative methodology	England, allocation in the health system between 2001 and 2011. Keynesian	Research into increasing financing in deprived areas, compared to more affluent areas, in relation to reducing inequalities	The policy was associated with a reduction in absolute inequalities in health by causes amenable to health care, while relative inequalities remained constant. The association between additional resources and reduced mortality was more pronounced in deprived areas than in wealthier areas.
Baptista et al., 2012 Parliamentary amendments.	Brazil, parliamentary amendments in the health budget between 1997 and 2006. Keynesian	Identifying the weight of budget amendments and exploring hypotheses that permeate the political and decision-making process in the distribution between regions and states.	Significant participation of amendments, especially in relation to investment resources. The nature of the implementation of the amendments seems to be more at the level of relations between Powers and governability. In this way, they stir up interests and reinforce practices that conflict with the prospect of reducing inequalities in health.
Porto et al., 2007 Allocative methodology	Brazil, allocation of federal resources for health in 1999. Keynesian	Evaluation of the applicability of methodologies for the distribution of federal resources among the states. Incorporating measures of need into geographic allocation formulas.	Social status is an important determinant of health conditions and a decisive factor in the use of health services. Demand models present limitations in contexts marked by great inequalities in access. In these contexts, health and social measures are less reflective of legitimate health needs, expressing barriers to access.

Continued

AXIS 9: FINANCING SOURCES			
Funcia, 2019 New financing sources	Brazil: underfunding of health and the effects of Constitutional Amendment No. 95. Keynesian	Identification of new sources of revenue for the additional allocation of resources to meet health needs.	The SUS needs new, permanent, stable and exclusive sources of revenue. Given a conflict of interests arising from tax reform, the search could begin with a citizen audit of the public debt and the waiver of revenue.
Ugá & Santos, 2006 Progressive financing.	Brazil: taxes that finance the SUS. Keynesian	Analysis of the burden of health financing on income groups and its degree of progressivity.	The SUS is financed by taxes and social contributions, so its level of equity is the same as the taxes that finance it. The Kakwani index identified corresponds to a system that burdens people proportionally to income. In an unequal society, this is highly questionable from the perspective of social justice.
AXIS 10: FINANCING NEEDS			
Rocha & Spinola, 2021 Projection of financing needs.	Brazil, health financing in the next four decades. Keynesian	Estimation and characterization of financing needs, identification of potential tensions between needs and spending restrictions in different fiscal scenarios.	Delays in responding to health demands can have harmful consequences, such as lower quality, increased segmentation and inequality. Efficiency gains could be reflected in higher quality and coverage under resource constraints, but there is no evidence that this has happened in the country.
Nossa, 2020 Projection of financing needs.	Portugal, constitutional rights and public policies. Keynesian	Questioning, based on a literature review, the discourse on the inevitability of increased costs, justified by aging.	States face neoliberal pressures that use the rationale of sustainability and intergenerational equity as a sufficient condition to justify progressive budget cuts or restrictions. The problem is not always based on evidence, even if some uncertainty prevails in relation to older people.
Puig-Junoy, 2006 Projection of financing needs.	Spain, projection of health financing needs 2006-2013. Keynesian	Present the results of the projections, using the following as cost drivers: demographics, rising input prices and the impact of innovations in medical practice.	The main factor responsible for the future increase in spending will continue to be the increase in the average intensity of health services, followed by demographic factors. The expansion of medical technology is expected to continue to be the main driver of future cost increases.

Source: Elaborated by the authors.

3. Results and Discussion

3.1. Convergences with Paul Singer's Thought

It is worth comparing the debate on the financing of post-1980 health systems with the reflections of [Singer et al. \(1978\)](#) in each of the dimensions highlighted: a) social control; b) historical perspective; c) health system; d) health status; and e) evaluation of health services, trying to identify whether the authors also appropriate these dimensions, verifying convergences, divergences, ruptures and continuities, given the historical horizon that separates the 1978 work from the most recent articles.

Firstly, the relationship between the dimensions and the articles is presented from a quantitative point of view. It was identified whether or not the dimensions are present in the identified studies. The health system dimension occurs in all 47 articles (100%), the consideration of the historical perspective in 43 articles (91.5%); evaluation criteria in 34 articles (72.3%); considerations about the health status of the population in 27 articles (57.4%); and social control in 11 articles (23.4%).

As for the thematic axes of the articles, the extent to which the dimensions of [Singer et al. \(1978\)](#) are present in each can be identified, which allows the main links with the themes identified in the literature to be mapped.

Table 3 shows the total number of articles per axis and those that use each of the dimensions of [Singer et al. \(1978\)](#), and **Table 4** shows this mapping for each article.

The most frequent results are articles that discuss Crisis and Austerity (axis 2) in the context of health systems (n = 8), from a historical perspective (n = 8).

Table 4. Relationship between the thematic axes of the review results and the dimensions of [Singer et al. \(1978\)](#).

Axis	Topic / No. of articles		Dimensions of Singer et al. (1978)									
			Historical perspective		Health system		Social control		Health status		Evaluation criteria	
			No. of articles	%	No. of articles	%	No. of articles	%	No. of articles	%	No. of article	%
1	Universal Systems and Capitalism	6	6	100.0%	6	100.0%	4	66.7%	3	50.0%	2	33.3%
2	Crisis and Austerity	8	8	100.0%	8	100.0%	1	12.5%	6	75.0%	5	62.5%
3	Systems reforms	5	5	100.0%	5	100.0%	1	20.0%	3	60.0%	5	100.0%
4	Health Policies and the Financing of PHC	6	3	50.0%	6	100.0%	2	33.3%	4	66.7%	3	50.0%
5	Decentralization	5	4	80.0%	5	100.0%	2	40.0%	3	60.0%	5	100.0%
6	Public Expenditure	5	5	100.0%	5	100.0%	1	20.0%	3	60.0%	3	60.0%
7	Public-private Relationship	4	4	100.0%	4	100.0%	0	0.0%	0	0.0%	3	75.0%

Continued

8	Resource Allocation	3	3	100.0%	3	100.0%	0	0.0%	2	66.7%	3	100.0%
9	Financing Sources	2	2	100.0%	2	100.0%	0	0.0%	1	50.0%	1	50.0%
10	Financing Needs	3	3	100.0%	3	100.0%	0	0.0%	2	66.7%	2	66.7%
	Total articles	47	43	91.5%	47	100.0%	11	23.4%	27	57.4%	34	72.3%

Source: Elaborated by the authors.

In turn, the historical dimension is quite present in discussions contextualized in contemporary capitalism (axis 1), since the articles that aims to shed light on this economic system do so by historically identifying the phases of the movement of capital ($n = 6$). The health status of is frequently emphasized in the articles ($n = 27$), present in 57.4% of all the studies, standing out quantitatively ($n = 6$) in relation to the total number of articles and percentage-wise (75%) within the thematic axis Crisis and Austerity, since the studies, in general, are very forceful in relating the impact of the reduction in funding for health policies to the problems generated by the crisis and the reduced access to HS.

Except for the articles on Universal Systems and Capitalism, which tend to be more theoretical, the dimension of evaluation criteria is present in at least half of the results for the other axes and, overall, in 72.3% of the results. This dimension plays a more important role in the articles that discuss system reforms, decentralization and resource allocation (100%).

Finally, the social control dimension is not very present, occurring in only 11 results (23.4%), concentrated in the axes Universal Systems and Capitalism ($n = 2$), financing of health policies ($n = 2$) and decentralization ($n = 2$). It can be seen that in the first axis, which discusses capitalism, social control is part of the discussion of the state in the capital-labor conflict. **Table 5** presents the mapping of identified articles.

Table 5. Mapping the dimensions of Singer et al. (1978) in the articles identified.

Article	Dimensions by Singer et al.				
	Historical perspective	Health system	Social control	Health status	Evaluation criteria
AXIS 1: UNIVERSAL SYSTEMS AND CAPITALISM					
Alves et al., 2019	•	•	•	•	•
Costa, 2017	•	•	•		•
Mendes & Carnut, 2018	•	•	•		•
Sestelo, 2018	•	•	•		
Machado et al., 2014	•	•		•	•
Mendes et al., 2018	•	•		•	•
AXIS 2: CRISIS AND AUSTERITY					
Borges et al., 2018	•	•		•	
Cantero Martínez, 2016	•	•	•	•	

Continued

de Souza, 2017	•	•		•	•
Giovanella & Stegmüller, 2014	•	•			•
Lehto et al., 2015	•	•			•
Massuda et al., 2018	•	•		•	
Santos & Vieira, 2018	•	•		•	•
Segura Benedicto, 2014	•	•		•	•
AXIS 3: SYSTEMS REFORMS					
Diderichsen, 1995	•	•		•	•
Atun et al., 2015	•	•	•	•	•
Massuda, 2020	•	•		•	•
Morosini et al., 2020	•	•			•
Seta et al., 2021	•	•			•
AXIS 4: HEALTH POLICIES AND THE FINANCING OF PRIMARY HEALTH CARE (PHC)					
Castro & Machado, 2010	•	•		•	
Chowdhury & Chowdhury, 2018		•		•	
Kershaw, 2020		•		•	•
Mendes & Marques, 2009	•	•	•		
AXIS 5: DECENTRALIZATION					
Rizzotto & Campos, 2016	•	•	•	•	•
Vieira & Santos, 2018		•			
Lima, 2007	•	•			•
Costa-Font & Gil, 2009	•	•	•	•	•
Puig-Junoy, 2006		•		•	•
de Paiva et al., 2017	•	•	•	•	•
Vazquez, 2011	•	•			•
AXIS 6: PUBLIC EXPENDITURE					
Campelli & Calvo, 2007	•	•		•	
Costa et al., 2015	•	•		•	•
Crozatti et al., 2020	•	•			•
Machado et al., 2017	•	•	•	•	•
Vieira, 2020	•	•			
AXIS 7: PUBLIC-PRIVATE RELATIONSHIP					
Andreazzi & Ocké-Reis, 2007	•	•			•
Bahia, 2005	•	•			•
Bahia, 2008	•	•			
Ocké-Reis, 2018	•	•			•
AXIS 8: RESOURCE ALLOCATION					

Continued

Baptista et al., 2012	•	•		•
Barr et al., 2014	•	•	•	•
Porto et al., 2007	•	•	•	•
AXIS 9: FINANCING SOURCES				
Funcia, 2019	•	•	•	
Ugá & Santos, 2006	•	•		•
AXIS 10: FINANCING NEEDS				
Nossa, 2020	•	•	•	•
Puig-Junoy & Rovira, 2004	•	•		
Rocha & Spinola, 2021	•	•	•	•

Source: Elaborated by the authors.

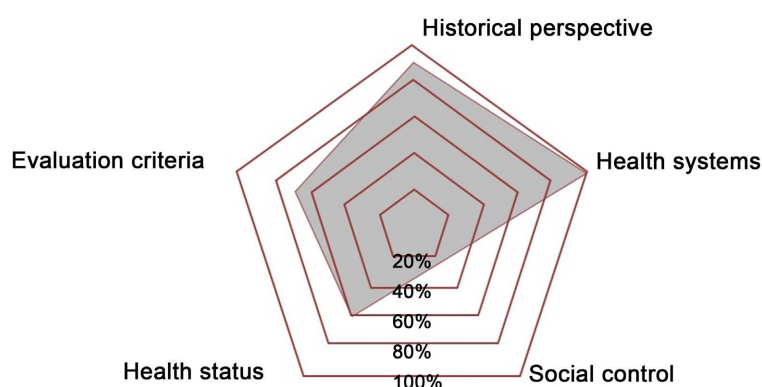


Figure 2. The frequency of dimensions in the articles reviewed.

Figure 2. Frequency of the dimensions proposed by Singer et al. (1978) in relation to the total number of articles ($n = 47$).

3.2. Historical Perspective

Singer et al. (1978) do not neglect to articulate the assessment of the HS with the historical perspective, recognizing the health status as a product of capitalist sociability, so that the factors considered, results and conclusions of health assessments do not deny historicity. The authors emphasize the HS as a historically constituted social unit, whose identity runs through the history of the country and the very identity of the West, also highlighting the issues of legal monopoly in the scope of the provision of health care and its complex hierarchy. This perspective is particularly important in criticizing neoclassical ideology and the type of evaluation resulting from it, focused on performance and efficiency, with major repercussions on the level of financing and allocation of resources within health systems, gaining importance in the context of the structural crisis of contemporary capitalism.

It can be seen that 42 articles (89.4%) historically contextualize the objects of discussion. The five articles (10.6%) that do not resort to the historical perspective are closer to Keynesian economic thought, with methodologies focused on data evaluation: expenditure projection (Puig-Junoy, 2006; Rocha & Spinola, 2021), access to medicines (Chowdhury & Chowdhury, 2018), articulation with other social policies (Kershaw, 2020) and with the 2030 Agenda (Vieira & Santos, 2018).

In articles closer to the Marxist perspective, historical contextualization is often taken as a discursive tool on the limitation of the capitalist State, which would not allow illusions regarding its role in the movement of capital (Mendes & Carnut, 2018).

Atun et al. (2015) take advantage of the historical, sociocultural and political context of Latin American countries to study their health system reforms in the last decades of the 20th century. Borges et al. (2018) use the context of structural reforms to contextualize measures imposed on Southern European countries, such as Spain and Portugal, from 2011 onwards.

In Brazil, historical mediation takes on special importance, given the historical and positional mismatch in global capitalism between the SUS, already established under the aegis of neoliberalism, and the welfare States systems of central capitalist countries (Alves et al., 2019; Mendes & Marques, 2009). Few articles address the period prior to the 1988 Constitution in search of the context and factors to discuss contemporary issues of SUS financing.

Sestelo (2018) briefly discusses the advent of the bourgeois revolutions in the central countries and the incorporation of new industrial technologies into the process of capitalist accumulation, with the implications for the health sector from the perspective of the category capital in process. In Brazil, emphasis is placed on the late industrial development in the 1930s, the acceleration of urbanization and the development of the modern state bureaucracy. This discussion is further developed by Singer et al. (1978) in order to identify the implications for the health situation. The authors noted that the process of full institutionalization of the HS was still underway in most non-developed countries. In Brazil, the role of the State in financing the consumption of medical care and paying for hospitalizations for third parties stood out (Singer et al., 1978: p. 129), in addition to the fragmented nature of health actions and services (Singer et al., 1978: p. 134).

The second half of the 20th century is also covered by other studies, with an emphasis on the structure of the health sector during the dictatorship, compared to the structure of the SUS, emphasizing the segmented and exclusionary nature of the social security system (Crozatti et al., 2020), the strong intertwining between the public and private sectors (Bahia, 2005; Machado et al., 2017) and the role of the State in the expansion of the private sector (Ugá & Santos, 2006). Limitations of the Brazilian health reform stand out, as it does not constrain the action of the market, ratifying the existing organization, without the necessary intensity for the institutionalization of a universal access model (Costa, 2017), not fully addressing structural deficiencies (Massuda et al., 2018) and the fiscal federalism

model (Lima, 2007).

3.3. Health Systems under the Aegis of the Capitalist State

Texts more focused on the Marxist approach identify systems in the context of capitalist accumulation. Sestelo (2018) raises the problem of global expansion in the supply of products, including those related to HS, and the constitution of stable purchasing demand, a context in which health care has acquired a privileged locus for capital in process. Singer et al. (1978) already identified the insertion of HS in a generalized perspective of “new products”, encompassing technological innovations in the health field, from the middle of the 19th century. As the satisfaction of consumer needs through the acquisition of scientific medical care was initially only available to the best-paid workers, voluntary health insurance associations were formed at first, and later state systems, as the vast majority of workers did not earn enough to join.

The context of transformations in capitalism and the workers’ movement has led to an increase in the responsibilities of States in the social area (Machado et al., 2014). Within the scope of the constitutional consolidation of social rights, such as health, Costa (2017) highlights the unfeasibility of the social pact without active government participation in the financing and coordination of the provision of public goods. In turn, Borges et al. (2018) recognize the historical conditions involved in the process, arguing that the social system of welfare States depends on the combination of an exceptionally strong consensus regarding its key points, in a historical context that favors the development of solidarity. This is not about, therefore, a perennial condition from a historical perspective. In the case of social protection in countries like Brazil, it is a matter of recognizing that it developed “late”, both in relation to the time and the historical moment that gave rise to it (Mendes & Marques, 2009), highlighting, also, its underfunding and the lack of “massive and class support” in the process of implementing the SUS in the face of neoliberalism (Funcia, 2019).

Singer et al. (1978: p. 30) expose the historical elements of the formulation of the capitalist State as a service and assistance provider, combining the need of capital for the consumption of new products in the health sector, the bargaining power of the rising working class over the State and companies, from the end of the 19th century, and the need to contain and disallow voluntary workers’ associations and the trade union movement, ensuring the loyalty of the working class to the established order.

Some Marxist thought articles expose this order established in capitalist society as the role of the State in the reproduction of capital. Mendes and Carnut (2018) highlight the specific political form of capitalism materialized in the State, as an essential element of production relations. This raises questions regarding the profile of the State’s actions. In the case of Brazilian, the coexistence of the universal system with dynamic and growing private markets (Machado et al., 2017) and subsidies favorable to the consumption of private goods and services (Ocké-Reis,

2018) express movements substantially contrary to the principles of the SUS, putting pressure on the implementation of universality, integrality and equity (Morosini et al., 2020).

Another approach to health systems involves addressing the specificities of the health sector and the level of uncertainty regarding care expenses. Costa (2017) highlights the unpredictability of the emergence of diseases and the uncertainty of their consequences, such as the risk of losing the ability to work and one's own life, as well as other articles that highlight the importance of social protection of health systems in the face of catastrophic expenditure (Atun et al., 2015; Costa, 2017; Chowdhury & Chowdhury, 2018). Although they do not use the concept of catastrophic expenditure, Singer et al. (1978) point to the creation of national health systems in order to meet the demand for access to the HS, which was made impossible by the income level of a large contingent of workers.

Another aspect widely addressed in the articles is the sustainability of systems in the face of factors such as demographic transition and aging (Diderichsen, 1995; Nossa, 2020; Rocha & Spinola, 2021; Santos & Vieira, 2018), the increase in the average intensity of use of SS (Puig-Junoy, 2006) and, above all, crisis scenarios (Cantero Martínez, 2016; de Souza, 2017; Diderichsen, 1995; Giovanella & Stegmüller, 2014; Lehto et al., 2015; Massuda et al., 2018; Santos & Vieira, 2018). Alves et al. (2019) criticize the predominant sense of sustainability in scientific production and warn of the need to insert the political form of capitalist sociability into the analysis of health systems.

3.4. Control of Problems Felt on a Social Level

For Singer et al. (1978: p. 17), HS are not directly part of the capitalist production process, but they play a crucial controlling role. In terms of their financing, capital needs to establish a certain degree of access and a certain level of financial resources for its own reproduction. Only 11 articles (23.4%) present elements that dialog with the dimension of social control, as defined by Singer et al. (1978). In this dimension, there is a predominance of Marxist articles ($n = 7$) over Keynesian ones ($n = 4$).

Keynesian thinking articles focus on the perspective of social cohesion and order, with concessions from the State in the health field. They highlight the evolution of State action in health, overcoming the model aimed at controlling contagious diseases that could lead to a public health problem (Cantero Martínez, 2016) and referring to social cohesion and guaranteeing equitable access to public goods (Costa-Font & Gil, 2009).

Articles closest to Marxist thinking do not fail to include health in the capital-labor conflict to discuss health financing (Alves et al., 2019), highlighting social policies in the mediation of their intrinsic contradictions (Sestelo, 2018), how much these are expressed in health (Machado et al., 2017), in the conflict between accumulation and legitimization of the social order (Rizzotto & Campos, 2016), and highlighting the State in the production of public policies towards the interests of the logic of capital (Mendes & Carnut, 2018). In Brazil, a structural

heterogeneity context of capitalism and profound backwardness of capitalist relations of production can be identified, reflected in the relations between capital and labor and in income inequality (Bahia, 2005). The right to health in the 1988 Constitution is pointed out as a solution by political elites to the social debt (Costa, 2017), integrating a context of Latin American reforms, struggles for democracy, tackling inequalities and demanding social rights (Atun et al., 2015).

If Singer et al. in 1978 placed the problem of evaluating HS in the context of the expansion of the field of medicine (increasing number of contradictions taken as health problems), in contemporary capitalism, which imposes the constraint of public financing, this discussion needs to be updated regarding the capacity of this expanded field to meet the needs and make the right to health effective. From the point of view of maintaining minimum levels of reproduction of working populations (Sestelo, 2018), criticism of the limitation of policy targeting and universal health coverage stands out (Costa, 2017; Massuda et al., 2018; Morosini et al., 2020; Rizzotto & Campos, 2016; Santos & Vieira, 2018). The current context requires attention in terms of updating the liberal ideology by incorporating, semantically modifying and reducing concepts from the progressive field, such as the notion of fairness, to the field of the possible liberal (Rizzotto & Campos, 2016: p. 264). The articles converge with Singer et al. (1978), by identifying that access to certain public goods is more related to a concession of capital to avoid the disturbance of the established order than to the realization of social rights, with the State assuming the role of regulatory body to repair the damage caused by contradictions.

3.5. Health Status of the Population

The health status dimension occurs in 27 articles. In Table 6, we classified these approaches under the aspects of the social context (social condition and demographics) and the organization of health systems (health policies and financial resources).

The crisis context is discussed in five articles, which relate austerity measures to the negative consequences on health status (Borges et al., 2018; de Souza, 2017), the possibility of reversing increased access to health services (Massuda et al., 2018), increased health needs (Segura Benedicto, 2014), and greater negative effects on the most vulnerable groups (Santos & Vieira, 2018).

Porto et al. (2007) argue that socially disadvantaged people tend to get sick more and use the health system less, characterizing inequity in the health system.

In a broader panorama of living conditions, Diderichsen (1995) links health conditions with aspects such as education, employment and economic resources. Atun et al. (2015) highlight that, in Latin America, improvements in health outcomes have resulted from economic development, increased income, improvements in health systems and universal coverage. Costa-Font & Gil (2009) expand this scope, highlighting the hypothesis of “relative income”, which, in addition to income distribution, introduces a psychosocial explanation, with factors such as stress and anxiety.

Two other articles address the issue of the production of health status under political and economic conditions from a Marxian perspective, differentiating between social determinants and the social determination of health (Mendes et al., 2018) and arguing that health levels are determined by these and not only by access to HS (Alves et al., 2019).

Some articles highlight the conditions of coverage and access, relating their expansion to improvements in results and a reduction in health inequalities (Campelli & Calvo, 2007; De Paiva et al., 2017; Machado et al., 2017; Rocha & Spinola, 2021), and highlighting possible negative consequences due to geographical inequality in access (Chowdhury & Chowdhury, 2018).

Primary Care stands out in producing better health results (Costa et al., 2015), and in its criticism of the biomedical and hospital-centric model, highlighting that its conception reaches the root of health problems, focusing on tackling them (Mendes et al., 2018).

Table 6. Relationships between contemporary aspects and health status.

Axis	Article	Contemporary aspects															
		Social context							Organization of the healthcare system								
		Social status			Demography				Healthcare policies					Financial resources			
		Impacts of the crisis	Political and economic constraints	Income transfer and health	Living conditions and health	Social determinants	Demographic changes	Lifestyle	HS coverage	Access to HS and treatment	Primary Care (PC)	Technology	Inadequate consumption of HS/Iatrogenesis	Development	Resource allocation	Investing in well-being	Underfunding
1	Alves et al., 2019	●															
	Machado et al., 2014														●		
	Mendes et al., 2018	●									●						
2	Borges et al., 2018	●															
	Cantero Martínez, 2016								●							●	
	de Souza, 2017	●															
	Massuda et al., 2018	●						●									
	Santos & Vieira, 2018	●															
	Segura Benedicto, 2014	●				●		●				●					

Continued

3	Diderichsen, 1995				•		•												
	Atun et al., 2015			•			•		•										
	Massuda, 2020						•												
4	Castro & Machado, 2010												•						
	Chowdhury & Chowdhury, 2018												•						
	Kershaw, 2020						•												
5	Rizzotto & Campos, 2016																	•	
	Costa-Font & Gil, 2009			•		•			•										
	Puig-Junoy, 2006																	•	
6	De Paiva et al., 2017																	•	
	Campelli & Calvo, 2007																	•	
	Costa et al., 2015																	•	
8	Machado et al., 2017																	•	
	Barr et al., 2014																	•	
9	Porto et al., 2007																	•	
	Funcia, 2019																		•
10	Nossa, 2020																	•	
	Rocha & Spinola, 2021																	•	
Total		5	2	2	1	3	5	2	6	3	2	2	1	1	3	1	1		
				11			6				14				5				

Source: Elaborated by the authors.

The technological apparatus is highlighted from the point of view of the continuity of investments (Costa et al., 2015) and the expansion of possibilities to contribute to the improvement of health status (Puig-Junoy, 2006), while the inadequate consumption of the HS and iatrogenesis are highlighted by Segura Benedicto (2014). Singer et al. (1978: p. 63) address this issue in the context of the medicalization of society and raise the paradox of the expansion of HS activities to the extent that it fails to achieve its objectives, demanding forms of evaluation and highlighting that the expansion of HS would not necessarily produce health. In the current clashes over the financing of health systems, this perspective deserves caution, given the possibility of its appropriation as a justification for the rationing of the HS.

When discussing the financing level and health status, Funcia (2019) highlights underfunding as a conditioning factor for health needs, while Cantero Martínez (2016) assumes that the allocation of financial resources is an investment in well-being and not an expense. The relationship between the way resources are allocated and health status is highlighted by three articles on inequalities (Barr et al., 2014; Machado et al., 2014; Porto et al., 2007).

Lifestyle perspective is present in three articles, relating changes resulting from the economic crisis (Segura Benedicto, 2014), possible impacts of the growing prevalence of obesity and sedentary lifestyle (Nossa, 2020) and healthy lifestyles as long-term policies to reduce health inequalities (Costa-Font & Gil, 2009). Mendes et al. (2018) warn that the emphasis on lifestyle deserves caution, given the notion of individual accountability, concealing the social production of disease (Singer et al., 1978: p. 50) and the structural conditions of inequalities resulting from the capitalist production mode.

Kershaw (2020) and Segura Benedicto (2014) advocate Health in All Policies (HiAP) approach, which assumes that public spending on social programs often has a stronger association with health than spending on HS. Singer et al. (1978) highlight the issue of alternative allocation of resources between HS and other public activities, on the one hand questioning the extent to which it contributes to improving health, and on the other hand emphasizing the contribution of the level of socioeconomic inequality and the different degrees of consolidation of health systems in this process.

Especially in countries with low public spending on health in relation to GDP, this approach cannot serve as a justification for the defunding of health policies. It is important to point out the risk of appropriating this discussion as a justification for the defunding of the public health system.

In the Brazilian context, the articles highlight the opportunistic way in which expenses from other sectors were taken to comply with Constitutional Amendment 29 (Campelli & Calvo, 2007; Mendes & Marques, 2009). Campelli & Calvo (2007: p. 1620) emphasize that the adoption of an expanded concept of health actions does not necessarily mean more financial resources for health, but rather more obligations to be paid with the same resources. Given the way the capitalist state works and the expansion of capital over public services, the risk of underfunding healthcare is heightened, replacing the notion of universality with targeted access based on meritocracy.

When presenting the issue of the criteria for evaluating the contribution of the HS to the health status of the population, Singer et al. (1978) emphasize the contradictions and compositions of political and economic interests in the health sector. This warning suggests the complexity of the activity, not allowing for early conclusions and disregarding the intentions of the actors.

3.6. Evaluation Criteria

When we understand financing as an important condition for the execution of services that make up health systems, we sought to identify the treatment of evaluation criteria that dialog with the financing level and the allocation of financial resources within the system. As far as the evaluation dimensions identified are concerned, there are a variety of criteria referenced or discussed, with varying degrees of objectivity (in terms of measurement capacity). The articles take different positions on the criteria:

- a) Description and use of the evaluation criteria, including the criteria for which the studies are non-judgmental, regardless of whether they reveal phenomena that may be positive or negative;
- b) Criticism of the evaluation criteria;
- c) Proposed evaluation criteria.

Table 7 shows the mapping and categorization of the main evaluation criteria identified in the articles.

There is a predominance of evaluation criteria for the purpose of describing or comparing the characteristics of systems, their services and their financing, in many cases, making up the methodology of studies.

Thus, a group of indicators that are useful for fostering discussions, comparisons and historical series can be verified. Indicators such as per capita expenditure ($n = 5$), expenditure in relation to GDP ($n = 3$) and public expenditure in relation to private expenditure ($n = 3$) are common in the literature that discusses health financing and, as such, are present in the studies identified.

It is found that some mapped criteria have a lower degree of objectivity. For example, investigating the relationship between public expenditure and health status ($n = 1$) or the level of financial protection provided by the health system ($n = 3$) requires more detailed questions, in line with [Singer et al.'s \(1978\)](#) question about what constitutes good health or the level of disruption acceptable for the reproduction of the capitalist system.

In turn, some studies criticize the criteria propagated by neoclassical ideology. The literature identified is predominantly critical of the emphasis on performance ($n = 6$), highlighting management tools, meeting targets and rewarding results, shedding light on the spread of managerialism in the health system ([Mendes & Carnut, 2018](#); [Rizzotto & Campos, 2016](#)).

Also noteworthy is the disregard of work processes in the evaluation, ignoring particularities of the organization of services and problems that result precisely from the lack of support, with the potential to generate “islands” of excellence to the detriment of services that need greater financial and operational support, widening inequities ([Mendes et al., 2018](#); [Morosini et al., 2020](#)). Performance is also discussed in relation to the mechanisms for transferring and allocating resources in the system. [Morosini et al. \(2020\)](#), [Mendes et al. \(2018\)](#), [Massuda \(2020\)](#) and [Seta et al. \(2021\)](#), when discussing Brazilian primary health care, criticize the calculation of intergovernmental transfers based on performance, under the discourse of rationalization and efficiency. In the context of the reform of Brazilian PHC, the criterion of weighted capitation ($n = 3$) has been criticized due to the focalizing nature of health policy, with threats to universality.

Also in the context of financial resources transfers, [Lima \(2007\)](#) criticizes the weight of the criteria of installed capacity and production of health services, in view of the restriction they impose on the equitable allocation and redistributive mechanisms of financial resources that take into account different demographic, epidemiological and socio-sanitary profiles.

Table 7. Main evaluation criteria identified, classified as description/comparison (a), criticism (b) or proposition (c).

		Evaluation criteria																										
Axis	Article	Capitation	Transfer of resources between entities and participation	Equity (allocation)	Equity (tax)	Expenditure in proportion to revenue	Expenditure in proportion to economic growth	Expenditure in proportion to GDP	Health expenditure in relation to expenditure on social policies	Public expenditure per capita	Public expenditure relative to private expenditure	Public expenditure and health status	GDP multiplier effect	Financial protection and direct disbursement	Population coverage and public financing	Investment in health	Health needs	Tax waiver on public expenditure	Sense of sustainability	Installed capacity	Performance and efficiency	Work processes	Production of the HS	Health outcome	User satisfaction and quality	Percentage of budget amendments and distribution	Aging and increased expenditure	Resource and technology intensity
1	Alves et al., 2019																		b									
	Costa, 2017									a			a															
	Mendes & Carnut, 2018							a													b							
	Machado et al., 2014				a		a		a																			
	Mendes et al., 2018																c				b		b					
2	de Souza, 2017													a	a											a		
	Giovanella & Stegmüller, 2014									a					a													
	Lehto et al., 2015							a																a				
	Santos & Vieira, 2018										a	a																
	Segura Benedicto, 2014																									a		
3	Diderichsen, 1995.			a																								
	Atun et al., 2015													a	a										a	a		
	Massuda, 2020	b																			b							
	Morosini et al., 2020	b																			b	c		b				
	Seta et al., 2021	b																			b							

Continued

[illegible]

Source: Elaborated by the authors.

Singer et al. (1978) justify research into evaluating the production of HS because of the characteristic ambiguity of these services in relation to other branches of production, since they are services whose activity is not the goal, but only a means to achieve a certain goal.

In this sense, indicators of the number of medical acts, consultations, hospitalizations and surgeries cannot be taken to measure the state of health of the population.

If the HS aim to produce health, the amount of its activity tends to be an inverse indicator of the degree to which this objective is being achieved. Less morbidity is related to less need to resort to HS.

Given the criticism of the criteria for transferring financial resources based on de-performance, it is precisely in this field that a criterion is proposed that is in tune with the perspective of equity, the criterion of health needs (Lima, 2007; Mendes et al., 2018; Porto et al., 2007; Vazquez, 2011).

Another criterion advocated concerns the assessment of the degree of equity in evaluating the performance of a health system, which would have as its main parameters the degree of equity in the production and maintenance of good health, in the use of the HS and in financing (Costa-Font & Gil, 2009). In turn, Alves et al. (2019) argue that the approach to the issue of health financing cannot be restricted to a specialized and technical discussion of neoclassical economics, disconnected from political and social discussions and re-served to factors such as performance, efficiency and costs, which has been predominant. It is worth noting that approaches to public services taken by managerialism and efficiency, with a view to rationalizing and containing public expenditure, did not assume, at the time of publication of the work by Singer et al. (1978), the process of health evaluation, so they did not gain prominence in their criticism. However, the way they present the problem of evaluating HS reveals their close relationship with the factors of the social environment that affect health, leaving no doubt as to the inappropriateness of the fragmented form of the neoclassical approach. Singer et al. (1978) focus their criticism on the accelerated expansion of the HS and the resources absorbed by it in relation to improving health. Seen from a historical perspective, this approach is consistent with the moment of capital experienced at the end of the 1970s of global expansion in the supply of products, including those related to HS, and the establishment of a stable purchasing demand. Therefore, there is no opposition in relation to the articles, but rather an overview of the movement of capital, in view of the return of financial capital, with a new role for the State in ensuring the full growth of its fictitious form and relevant developments in the arrangement of social protection and the capital/labor relationship.

3.7. Review Limitations

It is likely that the restriction of articles to Portuguese, English and Spanish explains the lack of studies discussing the systems in France and Italy and the small presence of the systems in Germany and Canada. In relation to the countries whose languages were included, there is a lower proportion of studies from the United Kingdom than from Spain, which may suggest that the depth of the austerity measures and the socio-economic position of this country in the European Union have led to a greater critical reaction in the field of political economy.

It is worth noting that in countries with fewer results, such as Costa Rica, Cuba and Canada, there is a more restricted approach to health systems, since the small sample is predominantly focused on specific issues, making it difficult to deepen

the discussion.

As for the historical moment of publication of the articles, it was found that the highest frequency of studies inserted in political economy occurs from 2004 onwards. It is not possible to state that the previous production is irrelevant, even if it is concluded that there is a gap in this production in the form of scientific articles indexed in the selected repositories.

To outline a broader panorama historically and in relation to the national systems studied, new reviews require the expansion of researched repositories and languages included.

4. Final Considerations

The discussion by [Singer et al. \(1978\)](#) turns to criticizing the criteria for evaluating health services, exposing the difficulty of relating their contribution to improving the population's level of health, and also sheds light on the insertion of health production in the context of producing indispensable conditions for capitalist sociability, from social, political and economic aspects. Thus, the forms and intentions of evaluation constitute a field for the mobilization of class interests, whether in the context of health services, the system and, mainly, its financing. From the point of view of health financing, the evaluation of services must be carefully considered, since, from the orthodox neoclassical perspective, the impact in terms of economic efficiency and performance is emphasized, which can compromise access and the realization of the right to health.

As contemporary universal health systems have been under attack in terms of reducing their financing schemes in the face of the capitalist crisis, the Marxist perspective seems to be the most appropriate to understand this context. This is because this view is anchored in a critical perspective of the form of civilization of domination and exploitation, the Capital, especially through the critique of Marx's political economy.

The intentionality of the evaluation in the health field must be taken into account, since it can be used to validate rationing and the targeting of actions and services. It is noted that the cuts of neoclassical evaluation instruments are taken as a technical justification for obtaining social consensus, even though they limit the implementation of social rights. Using political economy literature, we argue that evaluation should be used as an important tool to guarantee the right to health, especially in qualitative terms. The analysis of the results of the review shows that the sustainability of universal health systems should not be disconnected from the issue of the right to health, and that its implementation involves the political dispute for sufficient financial resources and the implementation of allocation instruments according to health needs.

Despite discussing a main theme, the reviewed articles recurrently used historical contextualization and paths that pass through different areas of the theoretical and operational fields of health systems, revealing an approach based on interconnections and reflections. These are characteristics similar to those of the

methodological approach of Singer et al. (1978), when taking the issue of health service evaluation, problematizing it and contextualizing HS in the capitalist production mode. The literature identified and the work of these authors converge in revealing the limitations of *Economics* in the face of the necessary insertion of the health issue within the scope of the interests that make up capitalist society, disregarding political and social aspects. The approach of social control by the capitalist State is important for understanding universal health systems, since in the current conflicts, it allows us to shed light on the issue of constraints imposed on the level of public health financing, which to some extent reposition the level of capital concession aimed at not disturbing the established order.

From a historical point of view, it is clear that the evolution of the HS is constant, and therefore the formation of health systems is the product of several factors, including demographic changes and technological incorporation, but also those resulting from the tensions between the interests of social classes. This understanding suggests the need for mobilization and response by the working class in the face of threats posed by health policies.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

- Alves, D. F. D. A., Carnut, L., & Mendes, Á. (2019). Dimensionamento da 'economia política' na 'economia da saúde': Para refletir sobre o conceito de sustentabilidade. *Saúde Em Debate*, 43, 145-160. <https://doi.org/10.1590/0103-11042019S513>
- Andreazzi, M. D. F. S., & Ocké-Reis, C. O. (2007). Renúncia de arrecadação fiscal: Subsídios para discussão e formulação de uma política pública. *Physis: Revista De Saúde Coletiva*, 17, 521-544. <https://doi.org/10.1590/S0103-73312007000300007>
- Atun, R., de Andrade, L. O., Almeida, G., Cotlear, D., Dmytraczenko, T., Frenz, P., Garcia, P. et al. (2015). Health-System Reform and Universal Health Coverage in Latin America. *Lancet*, 85, 1230-1247. [https://doi.org/10.1016/S0140-6736\(14\)61646-9](https://doi.org/10.1016/S0140-6736(14)61646-9)
- Bahia, L. (2005). Padrões e mudanças no financiamento e regulação do Sistema de Saúde Brasileiro: impactos sobre as relações entre o público e privado. *Saúde E Sociedade*, 14, 9-30. <https://doi.org/10.1590/S0104-12902005000200003>
- Bahia, L. (2008). As contradições entre o SUS universal e as transferências de recursos públicos para os planos e seguros privados de saúde. *Ciência & Saúde Coletiva*, 13, 1385-1397. <https://doi.org/10.1590/S1413-81232008000500002>
- Baptista, T. W. D. F., Machado, C. V., Lima, L. D. D., Garcia, M., Andrade, C. L. T. D., & Gerassi, C. D. (2012). As emendas parlamentares no orçamento federal da saúde. *Cadernos De Saúde Pública*, 28, 2267-2279. <https://doi.org/10.1590/S0102-311X2012001400006>
- Barr, B., Bamba, C., & Whitehead, M. (2014). The Impact of NHS Resource Allocation Policy on Health Inequalities in England 2001-11: Longitudinal Ecological Study. *BMJ*, 348, g3231. <https://doi.org/10.1136/bmj.g3231>
- Borges, F. T., Fernández, L. A. L., & Campos, G. W. D. S. (2018). Políticas de austeridade fiscal: tentativa de desmantelamento do Sistema Nacional de Salud da Espanha e resistência cidadã. *Saúde E Sociedade*, 27, 715-728. <https://doi.org/10.1590/S0104-12902018180043>

- Braga, J. C. S., & Paula, S. G. (1981). *Saúde e Previdência: Estudos de política social*. Hucitec.
- Campelli, M. G. R., & Calvo, M. C. M. (2007). O cumprimento da Emenda Constitucional nº. 29 no Brasil. *Cadernos De Saúde Pública*, 23, 1613-1623. <https://doi.org/10.1590/S0102-311X2007000700012>
- Cantero Martínez, J. (2016). Crisis and Mutation of the Public Health Service in Spain. *Derecho PUCP*, 76, 251-276. <https://doi.org/10.18800/derechopucp.201601.010>
- Carnut, L., Pires, J., & Mendes, A. (2021). Economia e saúde: Aproximações para uma abordagem da economia política crítica marxista. Marx e o Marxismo. *Revista do NIEP*, 9, 122-156. <https://doi.org/10.62782/2318-9657.2021.362>
- Castro, A. L. B. D., & Machado, C. V. (2010). A política de atenção primária à saúde no Brasil: Notas sobre a regulação e o financiamento federal. *Cadernos De Saúde Pública*, 26, 693-705. <https://doi.org/10.1590/S0102-311X2010000400012>
- Chowdhury, M. Z. I., & Chowdhury, M. A. (2018). Canadian Health Care System: Who Should Pay for All Medically Beneficial Treatments? A Burning Issue. *International Journal of Health Services: Planning, Administration, Evaluation*, 48, 289-301. <https://doi.org/10.1177/0020731417738976>
- Costa, N. D. R. (2017). Austeridade, predominância privada e falha de governo na saúde. *Ciência & Saúde Coletiva*, 22, 1065-1074. <https://doi.org/10.1590/1413-81232017224.28192016>
- Costa, R. M. D. D., Barbosa, R. D. S., & Zucchi, P. (2015). Expenditures in the Health Care System in Brazil: The Participation of States and the Federal District in Financing the Health Care System from 2002 to 2013. *Clinics*, 70, 237-241. [https://doi.org/10.6061/clinics/2015\(04\)03](https://doi.org/10.6061/clinics/2015(04)03)
- Costa-Font, J., & Gil, J. (2009). Exploring the Pathways of Inequality in Health, Health Care Access and Financing in Decentralized Spain. *Journal of European Social Policy*, 19, 446-458. <https://doi.org/10.1177/0958928709344289>
- Crozatti, J., Lima Junior, A. F. D., Lima, L. N., Oliveira, L. L. D., & Righetto, P. (2020). O gasto e as fontes do financiamento do SUS nos municípios brasileiros de 2003 a 2018. *Revista Ambiente Contábil*, 12, 200-218. <https://doi.org/10.21680/2176-9036.2020v12n2ID18708>
- De Paiva, A. B. D., Gonzalez, R. H. S., & Leandro, J. G. (2017). Coordenação federativa e financiamento da política de saúde: Mecanismos vigentes, mudanças sinalizadas e perspectivas para o futuro. *Novos Estudos CEBRAP*, 36, 55-81. <https://doi.org/10.25091/S0101-3300201700020004>
- de Souza L. E. P. F. (2017). The Right to Health in BRAZIL: A Constitutional Guarantee Threatened by Fiscal Austerity. *Journal of public Health Policy*, 38, 493-502. <https://doi.org/10.1057/s41271-017-0083-y>
- Diderichsen, F. (1995). Market Reforms in Health Care and Sustainability of the Welfare State: Lessons from Sweden. *Health Policy*, 32, 141-153. [https://doi.org/10.1016/0168-8510\(95\)00732-8](https://doi.org/10.1016/0168-8510(95)00732-8)
- Ferreira, M. R. J., & Mendes, A. N. (2018). Mercantilização nas reformas dos sistemas de saúde alemão, francês e britânico. *Ciência & Saúde Coletiva*, 23, 2159-2170. <https://doi.org/10.1590/1413-81232018237.12972018>
- Funcia, F. R. (2019). Subfinanciamento e orçamento federal do SUS: referências preliminares para a alocação adicional de recursos. *Ciência & Saúde Coletiva*, 24, 4405-4415. <https://doi.org/10.1590/1413-812320182412.25892019>
- Giovanella, L., & Stegmüller, K. (2014). The Financial Crisis and Health Care Systems in

- Europe: Universal Care under Threat? Trends in Health Sector Reforms in Germany, the United Kingdom, and Spain. *Cadernos De Saúde Pública*, 30, 2263-2281. <https://doi.org/10.1590/0102-311X00021314>
- Kershaw, P. (2020). A “Health in All Policies” Review of Canadian Public Finance. *Canadian Journal of Public Health*, 111, 8-20. <https://doi.org/10.17269/s41997-019-00291-4>
- Lehto, J., Vrangbæk, K., & Winblad, U. (2015). The Reactions to Macro-Economic Crises in Nordic Health System Policies: Denmark, Finland and Sweden, 1980-2013. *Health Economics, Policy, and Law*, 10, 61-81. <https://doi.org/10.1017/S1744133114000243>
- Lima, L. D. D. (2007). Conexões entre o federalismo fiscal e o financiamento da política de saúde no Brasil. *Ciência & Saúde Coletiva*, 12, 511-522. <https://doi.org/10.1590/S1413-81232007000200027>
- Machado, C. V., Lima, L. D. D., & Andrade, C. L. T. D. (2014). Federal Funding of Health Policy in Brazil: Trends and Challenges. *Cadernos De Saúde Pública*, 30, 187-200. <https://doi.org/10.1590/0102-311X00144012>
- Machado, C. V., Lima, L. D. D., & Baptista, T. W. D. F. (2017). Políticas de saúde no Brasil em tempos contraditórios: Caminhos e tropeços na construção de um sistema universal. *Cadernos De Saúde Pública*, 33, e00129616. <https://doi.org/10.1590/0102-311X00129616>
- Massuda, A. (2020). Mudanças no financiamento da Atenção Primária à Saúde no Sistema de Saúde Brasileiro: Avanço ou retrocesso? *Ciência & Saúde Coletiva*, 25, 1181-1188. <https://doi.org/10.1590/1413-81232020254.01022020>
- Massuda, A., Hone, T., Leles, F. A. G., Castro, M. C., & Atun, R. (2018). The Brazilian Health System at Crossroads: Progress, Crisis and Resilience. *BMJ Global Health*, 3, e000829. <https://doi.org/10.1136/bmjgh-2018-000829>
- Mendes, Á. (2015). A saúde pública brasileira no contexto da crise do Estado ou do capitalismo? *Saúde E Sociedade*, 24, 66-81. <https://doi.org/10.1590/S0104-12902015S01006>
- Mendes, Á. (2022). Crise do capital e o Estado: O desmonte da Saúde Pública brasileira em curso no neofascismo de Bolsonaro. In Á. Mendes, & L. Carnut (Eds.), *Economia Política da Saúde: Uma crítica marxista contemporânea* (pp. 96-153). Hucitec.
- Mendes, A., & Carnut, L. (2018). Capitalismo contemporâneo em crise e sua forma política: o subfinanciamento e o gerencialismo na saúde pública brasileira. *Saúde E Sociedade*, 27, 1105-1119. <https://doi.org/10.1590/S0104-12902018180365>
- Mendes, Á., & Marques, R. M. (2009). O financiamento do SUS sob os “ventos” da financeirização. *Ciência & Saúde Coletiva*, 14, 841-850. <https://doi.org/10.1590/S1413-81232009000300019>
- Mendes, Á., Carnut, L., & Guerra, L. D. D. S. (2018). Reflexões acerca do financiamento federal da Atenção Básica no Sistema Único de Saúde. *Saúde Em Debate*, 42, 224-243. <https://doi.org/10.1590/0103-11042018S115>
- Morosini, M. V. G. C., Fonseca, A. F., & Baptista, T. W. D. F. (2020). Previnhe Brasil, Agência de Desenvolvimento da Atenção Primária e Carteira de Serviços: Radicalização da política de privatização da atenção básica? *Cadernos De Saúde Pública*, 36, e00040220. <https://doi.org/10.1590/0102-311X00040220>
- Nossa, P. N. (2020). Envelhecimento, financiamento e inovação nos sistemas de saúde: Uma discussão necessária para a manutenção do direito à saúde. *Saúde E Sociedade*, 29, e200081. <https://doi.org/10.1590/S0104-12902020200081>
- Ocké-Reis, C. O. (2018). Sustentabilidade do SUS e renúncia de arrecadação fiscal em saúde. *Ciência & Saúde Coletiva*, 23, 2035-2042.

- <https://doi.org/10.1590/1413-81232018236.05992018>
- Porto, S., Martins, M., Travassos, C., & Viacava, F. (2007). Avaliação de uma metodologia de alocação de recursos financeiros do setor saúde para aplicação no Brasil. *Cadernos De Saúde Pública*, 23, 1393-1404. <https://doi.org/10.1590/S0102-311X2007000600014>
- Puig-Junoy J. (2006). Es la financiación sanitaria suficiente y adecuada [Health Care Financing: Is It Enough and Appropriate?]. *Gaceta Sanitaria*, 20, 96-102. <https://doi.org/10.1157/13086032>
- Puig-Junoy, J., & Rovira, J. (2004). Issues Raised by the Impact of Tax Reforms and Regional Devolution on Health-Care Financing in Spain, 1996-2002. *Environment and Planning C: Government and Policy*, 22, 453-464. <https://doi.org/10.1068/c0236>
- Rizzotto, M. L. F., & Campos, G. W. D. S. (2016). O Banco Mundial e o Sistema Único de Saúde brasileiro no início do século XXI. *Saúde E Sociedade*, 25, 263-276. <https://doi.org/10.1590/S0104-12902016150960>
- Rocha, R., Furtado, I., & Spinola, P. (2021). Financing Needs, Spending Projection, and the Future of Health in Brazil. *Health Economics*, 30, 1082-1094. <https://doi.org/10.1002/hec.4241>
- Santos, I. S., & Vieira, F. S. (2018). Direito à saúde e austeridade fiscal: O caso brasileiro em perspectiva internacional. *Ciência & Saúde Coletiva*, 23, 2303-2314. <https://doi.org/10.1590/1413-81232018237.09192018>
- Segura Benedicto, A. (2014). Recortes, austeridad y salud. Informe SESPAS 2014. *Gaceta sanitaria*, 28, 7-11. <https://doi.org/10.1016/j.gaceta.2014.02.009>
- Sestelo, J. A. D. F. (2018). Dominância financeira na assistência à saúde: A ação política do capital sem limites no século XXI. *Ciência & Saúde Coletiva*, 23, 2027-2034. <https://doi.org/10.1590/1413-81232018236.04682018>
- Seta, M. H. D., Ocké-Reis, C. O., & Ramos, A. L. P. (2021). Programa Previne Brasil: O ápice das ameaças à Atenção Primária à Saúde? *Ciência & Saúde Coletiva*, 26, 3781-3786. <https://doi.org/10.1590/1413-81232021269.2.01072020>
- Singer, P., Campos, O., & Oliveira, E. (1978). *Prevenir e Curar: O Controle Social Através dos Serviços de Saúde*. Forense Universitária.
- Ugá, M. A. D., & Santos, I. S. (2006). Uma análise da progressividade do financiamento do Sistema Único de Saúde (SUS). *Cadernos De Saúde Pública*, 22, 1597-1609. <https://doi.org/10.1590/S0102-311X2006000800008>
- Vazquez, D. A. (2011). Efeitos da regulação federal sobre o financiamento da saúde. *Cadernos De Saúde Pública*, 27, 1201-1212. <https://doi.org/10.1590/S0102-311X2011000600017>
- Vieira, F. S. (2020). Health Financing in Brazil and the Goals of the 2030 Agenda: High Risk of Failure. *Revista De Saúde Pública*, 54, Article 127. <https://doi.org/10.11606/s1518-8787.2020054002414>
- Vieira, F. S., & Santos, M. A. B. D. (2018). Contingenciamento do pagamento de despesas e restos a pagar no orçamento federal do SUS. *Revista De Administração Pública*, 52, 731-739. <https://doi.org/10.1590/0034-7612162491>