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Public Health Systems in the Age of Financialization: Lessons from France and Brazil

Les systèmes de santé publique à l'ère de la financiarisation:

Leçons de la France et du Brésil

THÈSE DE DOCTORAT

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The social costs of change rarely enter into the calculations and models of economists. They measure what they can more easily count (…). We have, therefore, to remind ourselves continuously about the reality, partly because we happen to be living in a scientific age which tends to associate the measurable with the significant, to dismiss as intangible that which eludes measurement, and to reach conclusions on the basis of only those things which lend themselves to measurement.

Richard Titmuss, 1968

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ABSTRACT

Contemporary capitalism is underpinned by the process of financialization – the expansion of the financial sector in size, scale, and power. Although this process is a key driver of transformations in the global economy, the mechanisms through which it reshapes Public Health Systems (PHS) remain poorly investigated. This thesis contributes to a better understanding of transformations in PHS by reassessing their trajectory from the fresh analytical framework of financialization. Incorporating this concept sheds light on actors, instruments, processes, and interests that have been critical in shaping reforms but which remain partially misapprehended.

We hypothesize that PHS are being reshaped by the process of financialization in ways that are functional for the expansion of the financial sector and the accumulation of financial capital. To investigate this hypothesis, we combine a theoretical discussion with an empirical investigation of two universal health systems, in France and Brazil. Following a mixed-method approach that combines qualitative and quantitative information, we demonstrate the implementation of financialized policies in each PHS since the 1990s. This means policies leading them to adopt financial logics, engage with financial instruments, and participate in financial accumulation strategies.

The first chapter introduces the topic of financialization and the inroads of finance into social provision. The second chapter conceptualizes PHS and suggests how to incorporate the notion of financialization into the analysis. The third and fourth chapters present the empirical findings. The conclusion systematizes these findings and elaborates a critical discussion on the problems associated with the adoption of financialized policies. We show that these policies transform PHS into vehicles for financial accumulation, decrease the stability of funding, and pose serious problems to democratic participation.

KEYWORDS: health system, financialization, financialization of health, public health, social security, social policy

RÉSUMÉ

Le capitalisme contemporain est dominé par la financiarisation – l’expansion du secteur financier en taille, échelle et pouvoir. Bien que ce processus soit un moteur essentiel des transformations de l'économie mondiale, les mécanismes par lesquels il refaçonne les systèmes de santé restent peu étudiés. Cette thèse contribue à une meilleure compréhension des transformations des systèmes de santé en réévaluant leur trajectoire à partir du cadre conceptuel de la financiarisation. En intégrant ce concept, nous mettons en évidence des acteurs, instruments, processus et intérêts qui ont joué un rôle crucial dans l'élaboration des réformes, mais qui restent mal appréhendés.

Nous formulons l’hypothèse selon laquelle les systèmes de santé publics sont remodelés par la financiarisation de telle sorte qu’ils favorisent l’expansion du secteur financier et l'accumulation de capital financier, au détriment de leurs fonctions de protection sociale. Pour vérifier cette hypothèse, nous combinons une discussion théorique avec une investigation empirique de deux systèmes universels, le français et le brésilien. Nous examinons la mise en œuvre de politiques financiarisées dans chaque système depuis les années 1990 – des politiques les amenant à adopter des logiques financières, à utiliser des instruments financiers et à participer à des stratégies d’accumulation financière.

Le premier chapitre introduit le thème de la financiarisation et les incursions de la finance dans la protection sociale. Le deuxième chapitre conceptualise les systèmes de santé et suggère comment intégrer la notion de financiarisation dans l’analyse. Les troisième et quatrième chapitres présentent nos analyses empiriques. La conclusion propose une discussion critique sur l’adoption de politiques financiarisées. Nous soutenons que ces politiques transforment les systèmes publics en véhicules d’accumulation financière, nuisent à la stabilité de son financement et fragilisent le caractère démocratique de sa gestion.

MOTS CLÉS: système de santé, financiarisation, financiarisation de la santé, santé publique, sécurité sociale, politique sociale

SUMMARY

TABLES 16

FIGURES 18

ACRONYMS 20

INTRODUCTION 22

Conceptualizing categories: Public Health Systems (PHS) 23
Neoliberalism and the challenges for universal health care 23
Incorporating financialization into the research on PHS change 26
Research design 31
Structure of the thesis 36
Contributions 37
Limitations 38

Chapter 1 Financialization and its paths into social provision 40

1.1 Finance and financialization 40
1.1.1 Finance and its workings: the conventional view 41
1.1.2 Finance from a heterodox perspective 43
1.1.3 The academic scholarship on financialization 46

1.2 Together but different: financialization in central and peripheral countries 50
1.2.1 Distinguishing central and peripheral financialization 50
1.2.2 Financialization in France 53
1.2.3 Financialization in Brazil 57

1.3 Financialization and social provision 63
1.3.1 The inroads of finance in areas of social provision 63
1.3.2 The financialization of social policies 64
1.3.3 The financialization of the State 68

Chapter 2 Public health systems in times of financialization 80

2.1. Public Health Systems (PHS) 81
2.1.1. Reasons for State intervention in health care 81
2.1.2. Defining public systems 83
2.1.3. Common institutional arrangements 84
2.1.4. PHS in historical perspective 87

2.2. The conventional conceptual framework on health systems change 94
2.2.1. Common terms to assess PHS reforms 94
2.2.2. Conventional understandings of PHS reforms: deconstructing the notion of privatization 96

2.3. Financialization in the health sector 100
2.3.1. The state of the art of the literature on the financialization of health 101
2.3.2. Gaps in the existing research on the public sector 106

2.4. Financialization as a distinctive type of PHS change 110

Chapter 3 The French system: pioneering financialized strategies in PHS 120

3.1. Social Security and public health care in France ... 120
3.1.1. The French system of Social Security ... 120
3.1.2. The French public health system: Assurance Maladie ... 124
3.2. Ameli's accounts in perspective ... 130
3.3. Mechanisms of financialization ... 133
3.3.1. Financialized strategies for long-term debt management: the Social Debt Amortization Fund ... 134
3.3.2. Financialized strategies for short-term financing by the Central Agency of Social Security ... 145
3.3.3. Government policies toward hospitals: credit-based investment programs ... 154
Chapter 4 The Brazilian system: a trajectory (mis)led by financialization ... 164
4.1. Social Security and public health care in Brazil ... 164
4.1.1. The Brazilian Social Security system ... 164
4.1.2. The Brazilian public health system: Sistema Único de Saúde ... 168
4.2. SUS accounts in perspective ... 175
4.3. Mechanisms of financialization ... 179
4.3.1. Permanent financial accumulation schemes fed by SUS revenues: policies at the federal level ... 180
4.3.2. Investing SUS revenues in short-term financial assets: policies at the subnational level ... 195
4.3.3. Subsidized credit lines for SUS providers ... 209
GENERAL CONCLUSION ... 226
Systematizing results: contrasts and common trends ... 227
The reconfiguration of PHS in financialized capitalism and the role of the State ... 231
Impacts of financialized policies on the foundational principles of PHS ... 233
Avenues for future research ... 237
REFERENCES ... 239
ANNEXES ... 275

TABLES

Chapter 3

Table 3.1 Health spending, total and public, France and selected regions, 2016 129

Table 3.2 France, Social Security and Illness branch (General Regime), financial balance, 2000-2017 131

Table 3.3 France, Illness Branch (General Regime), revenues, expenditure, and balance, 2000-2017.. 131

Table 3.4 France, Social Security's share in the consumption of care and medical goods, 1960-2015.. 132

Table 3.5 France, consumption of care and medical goods by source of funding, 1960-2015.. 132

Table 3.6 France, complementary insurance sector, 2001 and 2015, market share .... indicators 133

Table 3.7 France, Social Debt Amortization Fund (CADES), debt and revenues, 1996-2018.. 138

Table 3.8 France, Social Debt Amortization Fund (CADES) and State's interest rates, 2009-2017.. 141

Table 3.9 France, Social Debt Amortization Fund (CADES), interests and commissions, 1996-2018.. 142

Table 3.10 France, Social Debt Amortization Fund (CADES), purchase of securities by type of investor, 2009-2017 144

Table 3.11 France, Central Agency of Social Security Organizations (ACOSS), external financing by instrument, 2004-2018 149

Table 3.12 France, ACOSS and State interest rates, annual average, 2007-2017 151

Table 3.13 France, Central Agency of Social Security Organizations, revenues and expenditures from banking and financial market operations, 2009-2018........................ 152

Table 3.14 France, public hospital sector, investment and debt indicators, 2003, 2009-2018.. 157

Table 3.15 France, interest rates of public hospital debt and Treasury bonds, 2005-2018.. 159

Chapter 4

Table 4.1 Brazil and selected countries, total and public health spending, 2016............. 174

Table 4.2 Brazil, Social Security budget, 2005-2018 176

Table 4.3 Brazil, expenditures on public health actions and services (ASPS), 1980, 1990, 2005-2017.. 178

Table 4.4 Health expenditures by subfunction, federal and local governments, 2000, 2005, 2010-2017.. 178

Table 4.5 Brazil, health spending, public and private, 2000-2017.................................. 179

Table 4.6 Brazil, interest and inflation rates, 1996-2018 183

Table 4.7 Brazil, fiscal policy indicators, federal government and total public sector, 2000-2018 189

Table 4.8 Brazil, federal government expenditures on public debt interests and health, 2000-2018 190

Table 4.9 Brazil, Unbinding of Union Revenues (DRU) and selected indicators of federal government accounts, 2010-2018 193

Table 4.10 Brazil, Rio de Janeiro State Health Fund, financial investments, 2012-2018 202

Table 4.11 Brazil, Rio de Janeiro State Health Fund, financial assets by nature of institution, 2012-2018 203

Table 4.12 Brazil, Federal District Health Fund, financial assets, 2012-2018 204

Table 4.13 Brazil, federal transfers for SUS services and deductions from medium- and high-complexity services (MAC), 2010-2018 219

Conclusions

Systematizing findings 1: France (Assurance Maladie) 228

Systematizing findings 2: Brazil (Sistema Único de Saúde) 229

Annexes

Annex 1. Privatization and Financialization in the Health Sector 275

FIGURES

Introduction

Figure I Empirical Framework 33

Chapter 3

Figure 3.1 France, Social Security system (General Regime), simplified scheme of financial flows 123

Figure 3.2 France, Social Debt Amortization Fund (CADES), accumulated debt and revenues, 1996-2018 139

Figure 3.3 France, Social Debt Amortization Fund (CADES), financial results per year, 143

Figure 3.4 France, Central Agency of Social Security Organizations, financial securities (total amounts issued and participation in total short-term borrowing), 2004-2018 149

Figure 3.5 France, Central Agency of Social Security Organizations, revenues and expenditures, banking and financial market operations, 2009-2018 152

Chapter 4

Figure 4.1 Brazil, Public health system (SUS), simplified scheme of financial flows 170

Figure 4.2 Brazil, federal government expenditure on health and public debt interests, 2000-2018 190

Figure 4.3 Brazil, Federal government expenditures (% federal budget), 2018 191

Figure 4.4 Brazil and selected aggregates, central government expenditures with public debt transactions and health 192

Figure 4.5 Brazil, Rio de Janeiro State Health Fund, Financial assets (right axis) and returns (left axis), 2012-2018 202

Figure 4.6 Brazil, Federal District Health Fund, Financial assets (right axis) and returns (left axis), 2012-2018 205

Figure 4.7 Brazil, philanthropic health establishments, total sector debt and debt structure, 2005-2015 213

Figure 4.8 Consigned credit to philanthropic hospitals (simplified scheme) 216

Figure 4.9 Brazil, values deducted from federal transfers for medium- and high-complexity services (MAC) for consigned loans and other items, 2010-2018 220

Figure 4.10 Brazil, federal transfers for SUS (selected categories) and values deducted from federal transfers for medium- and high-complexity services (MAC), 2010-2018 ... 220

ACRONYMS

Acronym	Original (English Translation − if applicable)
ACOSS	Agence Centrale des Organismes de Sécurité Sociale (Central Agency of Social Security Organizations)
AMELI	Assurance Maladie
ANFIP	Associação Nacional dos Auditores Fiscais da Receita Federal (National Association of Fiscal Auditors of the Federal Internal Revenue Service)
AP-HP	Assistance Publique - Hôpitaux de Paris
CADES	Caisse d'Amortissement de la Dette Sociale (Social Debt Amortization Fund)
CCSS	Commission des Comptes de la Sécurité Sociale
CGU	Controladoria Geral da União (Office of the Comptroller General)
CRDS	Contribution au Remboursement de la Dette Sociale (Contribution for the Reimbursement of the Social Debt)
CSG	Contribution Sociale Generalisée (General Social Contribution)
DF	Distrito Federal (Federal District)
DREES	Direction de la Recherche, des Études, de l'Évaluation et des Statistiques
DRU	Desvinculação de Receitas da União (Unbinding of Union Revenues)
ECB	European Central Bank
ERJ	Estado do Rio de Janeiro (Estado do Rio de Janeiro)
FES	Fundo Estadual de Saúde (State Health Fund)
FMS	Fundo Municipal de Saúde (Municipal Health Fund)
FNAS	Fundo Nacional de Assistência Social (National Social Assistance Fund)
FNS	Fundo Nacional de Saúde (National Health Fund)
IBGE	Instituto Brasileiro de Geografia e Estatistica (Brazilian Institute of Geography and Statistics)
IMF	International Monetary Fund
IPC	Indice des Prix à la Consommation (Consumer Price Index)
IPCA	Índice de Preços ao Consumidor – Amplo (Consumer Price Index)
OF	Orçamento Fiscal (Fiscal Budget)
OSS	Orçamento da Seguridade Social (Social Security Budget)
PHS	Public Health Systems
PFI	Private Finance Initiatives
PPP	Public-Private Partnerships
SES	Secretaria Estadual de Saúde (State Health Secretariat)
SFC	Secretaria Federal de Controle Interno (Federal Internal Control Secretariat)
SIB	Social Impact Bonds
SMS	Secretaria Municipal de Saúde (Municipal Health Secretariat)
SNA	Sistema Nacional de Auditoria (National Auditing System)
STN	Secretaria de Tesouro Nacional (National Treasury Secretariat)
SUS	Sistema Único de Saúde (Unified Health System)
SEF	Secretaria de Estado de Fazenda (State Department of Finance)
TCU	Tribunal de Contas da União (Federal Court of Accounts)
UHC	Universal Health Coverage
WHO	World Health Organization

INTRODUCTION

Health is a fundamental human right, a social goal, and an economic imperative (WHO, 1978). Universal access to health care – meaning that all individuals of a country are entitled to receive the services they need, irrespective of their financial situation – has been one of the chief claims of social and political movements over the past century.

Today, the quest for universality remains critically important. Global trends in health care have been a cause for concern; by the end of the 2010s, at least half of the world population still lacked access to essential health services, and almost 100 million people were pushed into extreme poverty each year due to health expenses (WHO, 2017). In several countries, inequalities and exclusion from access to health care have either persisted or deepened over the past years. Estimates suggest that, between 2000 and 2010, the share of the world population facing "catastrophic health payments" – when over one-tenth of the household budget goes to health care expenditures – increased from 9.7% to nearly 12%. This rise was observed in almost all world regions, including Africa, the Americas, and Europe (WHO, *op. cit.*).

Even wealthy nations now struggle to promote universal and equal access to health care. In the OECD region, where most countries are committed to providing comprehensive public health assistance, national surveys find that the main reason leading individuals to give up on seeking medical care is the lack of income to cover the costs of services. Data for the average of OECD countries in 2016 show that approximately 14% of the population reported unmet health care needs due to financial constraints. Naturally, this hit the most vulnerable the hardest; among low-income individuals (those living in households with income below 50% of the national average), the share of the population with unmet health care needs reached 25%. In France, a country widely recognized for its universal health system, these percentages were 14% for the entire population and 30% in the lower income strata (OECD, 2017).

The importance of having proper access to care became strikingly clear in 2021 with the COVID-19 outbreak, one of the worst pandemics of modern history. By early December 2021, official statistics counted more than 5.2 million deaths from the disease (WHO, 2021), a striking and underestimated figure. Unlike other modern pandemics, the COVID-19 pandemic had devastating effects across low-, middle-, and high-income countries. It showed that they are all exposed to the dangers of not prioritizing investments in health care access and infrastructure on an ongoing basis.

The challenges for expanding and securing access to health care over the past decades have gone hand in hand with a changing approach to State intervention since the 1980s guided by the neoliberal paradigm. This approach has been imposing ongoing reforms on public health systems.

Conceptualizing categories: Public Health Systems (PHS)

The recognition of health care as a fundamental right led several nations to create public health systems (PHS). A health system can be defined as the ensemble of institutions, resources, and people involved in the financing, organization, and delivery of health services at the national level (WHO, 2010a). In many countries, the State or a political body (such as a Social Security system) is committed to financing and ensuring the population has access to a wide range of health services. It guarantees access to health care as a constitutional right, independent from one's capacity to pay. Individuals are entitled to access care at all levels they may need throughout the life cycle, including services related to prevention, healing, and rehabilitation (i.e., primary, secondary, and tertiary care).

We adopt the concept of PHS to refer to the health systems created by public powers to fulfill these goals. We include all national health systems in which (i) the government or another public entity assumes the chief role in financing services or insurance and (ii) the system follows principles of universality, equity, solidarity, and comprehensive health care provision. Today, PHS can be found across several high and middle-income countries, with distinctive institutional arrangements and at varying degrees of consolidation. Important examples of countries with public and comprehensive health systems include England (*National Health Service*), France (*Assurance Maladie)*, Italy (*Servizio Sanitario Nationale*), Canada (*Medicare*), Israel (*National Health Insurance*), Brazil (*Sistema Único de Saúde),* Costa Rica *(Caja Costarricense de Seguro Social*), and Cuba (*Sistema Nacional de Salud*), to mention a few.

PHS represent a crucial step toward ensuring access to health care as a fundamental right. In the countries in which they exist, these systems represent the main gateway of access to services by the population. Moreover, they can mitigate the high inequalities and exclusions from access typically observed in countries dependent on private financing by offering services according to medical needs rather than the ability to pay. As they provide a socially acceptable standard of services to which all citizens have equal access, PHS can foster social equity like few other institutions in a country. The relevance of PHS transcends national frontiers by also serving as blueprints for countries still in the quest for expanding and universalizing access to health care.

Despite not having necessarily diminished in size and importance, these systems seem to be falling short in their capacity to meet the health care needs of the population. Taking a closer look at the reforms imposed on them over the past decades can provide valuable insights for understanding these challenges.

Neoliberalism and the challenges for universal health care

PHS reforms are far from new. Since the 1980s, the idea of comprehensive State provision has been under intense pressure in the context of a new economic paradigm taking over economic ideology and practice. This is commonly referred to as *neoliberalism.* Neoliberalism emerged in the 1970s as a political project advocating in favor of policies that were supposed to be necessary for individual entrepreneurship and freedom to flourish.

These included, first, policies for protecting private property rights and profits, and second, for promoting free financial markets and trade. Such objectives were placed above virtually all other policy goals (Yilmaz, 2017). Today, the term neoliberalism can be used broadly to refer to a set of economic and political ideas, as well as the policies, institutions, and practices accompanying these ideas, which advocate for unregulated markets and favor private capital (Fine and Saad-Filho, 2017). The neoliberal ideology is heavily based on the narrative that "big governments" disempower individuals, waste resources, and create disincentives for private enterprise. This narrative fuels a critique of all forms of institutionalized solidarity between citizens, calling for budget discipline and the suppression of universal public provision (Yilmaz, *op. cit.*).

Public health policies, and PHS in particular, can absorb a significant share of the public budget. According to the WHO, in 2018, global health spending was around eight trillion dollars, or 10% of the world GDP. The public sector was responsible for the largest part of this funding; about 60% of global health spending came from the public sector (WHO, 2019). The lion's share of public health spending comes from countries with universal PHS. In Europe, where these systems are the most consolidated, health expenditure usually accounts for the second largest item of general government expenditure, at an average of 8.2% of the GDP in 2018 (OECD, 2021a, 2021c).

The public budget represents one of the main arenas of political dispute in the neoliberal era. It is no surprise, then, that the neoliberal paradigm radically changed the landscape of public health policy. From the neoliberal lens of austerity and private market efficiency, public health expenditures represent a high and increasing burden on the government budget. A large share is considered a waste of resources that funds supposedly inefficient service provision (André and Hermann, 2009; Bayliss, 2016; Maarse, 2006). France offers a recent and sound illustration of this state of affairs; in October 2017, the newly appointed Minister of Health drew attention from the media by claiming that about 30 percent of public spending on the French universal health system was "*not pertinent",* with significant *"room for maneuver*" for a "*smooth revolution*" (Le Journal du Dimanche, 2017). The following year, almost €2 billion were cut off from the system's main fund (La Tribune, 2018).

Neoliberal reforms came about offering solutions for the supposed excessive costs of public provision. These are usually associated with government efforts to reduce public health spending by compressing the wages of health professionals, capping hospital budgets, downsizing or outsourcing public services, and introducing or increasing co-payments for patients, to cite a few. There is a vast international literature demonstrating that these changes take on specific forms in each country but are similarly informed by the neoliberal ideology. This literature also calls attention to the detrimental effects of these so-called "policy adjustments" on the conditions of access to health care by the population. Evidence from single and cross-country studies show that neoliberal reforms have often contributed to deteriorating the quality and quantity of public services, without bringing superior outcomes in terms of saving costs or improving efficiency. They also find that these reforms tend to deepen inequalities in access to care, once the burden of health expenses is pushed onto

individuals and private insurers (André et al., 2015; Böhm, 2017; Hassenteufel and Palier, 2007; Ortiz et al., 2015; Whitfield, 2015; Yilmaz, 2017).

As of today, the metamorphoses in public health systems seem far from over. The confrontation between advocates for health care based on solidarity and universalism, on the one hand, and neoliberal reformers, on the other, "*has devolved into a cacophony of shrill voices and combative viewpoints*" (Stuckler and Basu, 2013, p. xi). This dissonance feeds the diversification of reforms in countries with universal systems and the spread of radically different frameworks for universal provision where these systems are yet to be consolidated. In this latter case, the traditional approach to public systems based on the idea of *universal health care* has been challenged by an alternative vision of universality promoted by multilateral institutions based on the idea of *universal health coverage* (Stuckler et al., 2010), with far more limited scope for public provision and capacity to reduce health inequalities.

The devastation caused by the COVID-19 pandemic has breathed new life into the debate on neoliberal reforms in PHS. It opened space to question how decades of continuous cuts and restrictions on these systems' financial, material, and human resources may have eroded their capacity to address the health crisis. Using a sample of 147 countries, Assa and Calderón (2020) show that higher rates of private health expenditure at the national level are associated with both higher prevalence and mortality rates related to COVID-19. The authors argue that the decades of austerity and privatization preceding the pandemic have contributed to reducing equipment and personnel in public systems, undermining countries' preparedness to fight the virus. Also, previous measures would have increased inequality in health care coverage, leading individuals to respond differently to the disease and making it more difficult to control it. Popic (2020) reminds that, as the hospitals that deliver costly specialized care in Europe are still predominantly public, one of the key cost-containment measures since the 1990s has been to reduce the number of hospital beds in the sector. The main targets of these measures were beds dedicated to treating severe and long-term conditions, which are more expensive to maintain than those for short-term stays. But these included the beds suited to treating the worse symptoms associated with COVID. In Italy, the number of acute care beds per 1,000 people dropped from 7 in 1990 to 2.6 in 2017 (Prante et al., 2020). In France, the number of long-term hospital beds fell by more than 50,000 since 2003 (DREES, 2019a), while the public hospital budget lost approximately €12 billion over the last decade (Petit, 2020). It is inconceivable to imagine that such types of cutbacks, similarly observed in several other countries, did not affect the capacity to fight the pandemic.

The discussion above shows that neoliberal reforms do not eliminate public systems, but undermine their capacity to guarantee and expand quality health services for the population. In light of the fact that these reforms do not seem to favor the population at large, since acting against universality and equity, it is important to interrogate what are the pressures leading to transformations in public systems today and who they truly benefit. As we will argue in this thesis, the concepts most commonly employed by the literature on health systems change, such as *privatization*, seem no longer sufficient to fully grasp the drivers, characteristics, and impacts of these reforms. Now, such a task requires

acknowledging and investigating the role of *financialization*, one of the chief drivers of current transformations in the world economy and State activities.

Incorporating financialization into the research on PHS change

The existing research on neoliberal reforms in PHS has long drawn attention to the role of private actors in pushing and profiting from these policy shifts. Their involvement in these reforms has been examined through now well-known concepts such as "commodification" and "privatization". Although the conceptual framework established by previous research has been instrumental to understanding reforms in PHS, it does not seem sufficient to apprehend the current nature of changes in these systems and the actors at play. Research in the field has been paying little attention to a notion that is critically important to examine developments taking place in the present stage of capitalism: financialization.

The concept of financialization has been used for over a decade to designate a collection of changes in our economic system that began in the 1970s and have been accelerating since the 1990s (Chiapello, 2017). These changes reflect three interconnected processes in the global economy; the growing size of the financial sector, its expansion in scope, and its progressive concentration of wealth and power relative to other actors (Gabor, 2018). One of the most popular and comprehensive definitions of financialization has been laid down by Epstein (2005), who describes it as "*the increasing role of financial motives, markets, actors, and institutions in the operation of the domestic and international economies*" (p. 3). As research in the theme evolved, it became clear that the influence of financial markets and institutions extended beyond the realm of "economies". Aalbers' (2019) revised version of this definition seems to better capture the current reach of the process of financialization, defining it as "*the increasing dominance of financial actors, markets, practices, measurements, and narratives, resulting in a structural transformation of economies, firms, States, and households"* (p. 4).

When referring to the financial sector, we mean here the architecture of institutions, instruments, and markets that manage the use of money for payments, savings, and investments (SIDA, 2004). Financial institutions can be broadly understood as the companies responsible for carrying out these activities. Among the most prominent financial companies responsible for the conduct and growth of economic transactions today, we can mention commercial banks, investment banks, institutional investment funds, insurance companies, and the financial arms of transnational companies, along with the investors at the top of the "financial pyramid" (Guillen, 2014). The five hundred largest asset management firms in the world had over US$104 trillion in assets under management in 2019 (Thinking Ahead Institute, 2020) – more than seven times the GDP of the European Union in the same year. This serves as an illustration of the power that these institutions hold today over the economy at large and governments in particular.

From a critical perspective, financial institutions manage money for themselves and others, and seek to multiply the resources they manage through loans, investments, and speculation in financial markets (Appadurai, 2015; Chesnais, 2016). Over the past decades, these actors have gained an unprecedented ability to "make money from money" (Mulligan,

2016), becoming one of the main channels of concentration of income and wealth in contemporary capitalism (Epstein et al., 2003; Lapavitsas, 2013; OXFAM, 2015). In 2017, the global distribution of dividends to shareholders surpassed the one trillion euro mark for the first time in history (l'Humanité, 2018), mostly addressed to a minor, most affluent share of the population.

Critical studies of financialization constitute today a solid body of literature comprising works from different scientific fields and theoretical perspectives. Among their common traits, they tend to express concerns about the implications of such a process on a wide array of social, economic, and political matters (Hein et al., 2015; Mader et al., 2020). According to this literature, the subordination of individuals, governments, and companies to a new center of power, located in the financial sector, is one of the central and most problematic traits of financialization. While the relative growth of finance in the economy has been a recurrent trend in capitalism (Arrighi, 1994), the present period stands out as this expansion now determines patterns of economic growth, income distribution, capital investment, consumption, international trade, capital flows, State action, and even personal beliefs and lifestyles (Durand, 2017; Fine and Saad-Filho, 2017; Guttmann, 2008). As such, the process of financialization can be considered the underpinning of the present stage of (neoliberal) capitalism (Fine and Saad-Filho, 2017), not least as it shapes production, accumulation, and the social basis that enables them to happen.

The massive inroads of the financial sector into previously "sacred" areas of human life is one of the chief traits of the financialization process (Fine, 2014; Lavinas, 2018a; Stenfors, 2016). This includes notably areas of social provision – that is, areas associated with social rights and where the State often guarantees some degree of provision, such as health care, pensions, housing, education, and income support. In reviewing the literature on financialization, we find authors that demonstrate the transformative effects of financialization on both ends of social provision. On the one hand, governments seem ever more reliant on financial instruments and institutions to finance and provide goods and services in areas associated with social rights (Chiapello, 2017; Karwowski, 2019); on the other, individuals are increasingly dependent on financial instruments and institutions to access them, largely encouraged by governments themselves (Fine, 2014; Lavinas, 2018b). Financialization trends in social provision are of particular concern in light of their potential to undermine principles of universality, equity, and solidarity. The expansion of financial capital in such areas pressures in favor of decisions that maximize returns and minimize risks for investors, often at the expense of increasing investments and expanding service provision (Bayliss, 2016; Fine, *op. cit.*; Lavinas and Gentil, 2018; Mulligan, 2016; Vural, 2017).

Despite evidence that financialization influences government decisions in areas of social provision, there is little published research on how this process has been reshaping PHS. This prevents us from gaining a deeper understanding of ongoing developments in the field, once financial actors and instruments have particular *modi operandi* that requires the use of specific concepts if one seeks to capture how they might be reshaping health systems.

Turning to the more recent literature on financialization, studies looking at how this process reshapes the health sector constitute a flourishing area of research (Hunter and

Murray, 2019). However, the investigations that apply the concept of financialization to understand changes in health care have been mainly focused on private activities, where changes driven by the financial sector can be more easily perceived. There is particular attention to how hospitals, insurance companies, pharmaceutical industries, and other segments of private provision are changing under the pressures of financialization. Several studies show how actors in these segments are becoming integrated into the financial sector and incorporating behaviors typical of financial institutions (Abecassis and Coutinet, 2018; Bahia et al., 2016; Lavinas and Gentil, 2018; Martins et al., 2021; Mulligan, 2016; Sestelo, 2017a; Vural, 2017). The high profitability of financial companies operating in health stands out as a worldwide phenomenon, observed even in countries with public and universal provision. For the sake of illustration, in 2016, the French insurance company AXA reported the largest annual profits in its history up to that point, over €6 billion, pointing to health insurance plans as their chief source of profits (Les Echos, 2017). In Brazil, private insurance companies recorded approximately €1.6 billion in profits in 2016, an increase of 70% relative to the previous year (Valor Econômico, 2017).[1]

In contrast to the private sector, there is still much to learn about the impacts of financialization in the public health sector. Public services often remain free or highly subsidized at the point of access, making it more difficult for users and even policymakers to understand restructurings taking place due to the pressures of global finance (Bayliss et al., 2016a). Studies looking at public health activities tend to focus on specific points of the chain of provision. There is well-deserved attention to the phenomenal growth of private investments to build public infrastructure, including public hospitals (Bayliss and Waeyenberge, 2017; Fine, 2020; Loxley and Hajer, 2019). Another area related to public intervention that has been the object of recent discussion is global health policy, where attention is placed on how financial institutions and markets influence the design and funding of international initiatives to improve population health (Stein and Sridhar, 2018; Tchiombiano, 2019). One last hot topic related to public intervention are "social impact bonds" and other financial contracts, which are being used to finance specific actions in a wide array of public policy areas, including health (Hunter and Murray, 2019; Lavinas, 2018b).

When it comes to PHS, however, financialization is almost always associated with austerity and cuts in public provision, which consequently reduces the space these systems occupy in the economy and for society. In other words, the usual perspective on how this process impacts public systems emphasizes its role in restricting public health spending and thereby undermining the capacity of these systems to provide good quality services.[2] Another common association describes how these constraints on public systems would boost the demand and profits of private activities, favoring the financial actors involved in private health care. We agree with these arguments and recognize their importance for understanding current events. Still, it is clear that, from this perspective, PHS appear as

[1] R$6.2 billion, adjusted according to the average exchange rate of 2016.
[2] The links between financialization and austerity are explored in chapter 1.

passive agents in the process of financialization of health, serving as a supporting apparatus for the expansion of finance in the private sector.

However valid, the image of the public sector as simply favoring the financialization of health through private activities provides an incomplete picture of present-day developments in health care. PHS account for a significant, often the largest share of financial, material, and human resources for health care provision at the national level. This translates into large funding requirements and a vast existing infrastructure with the potential to grow further. We argue that, in times of financialization, these systems represent important avenues for the expansion of financial capital. Financial players are likely to be interested in lending to PHS and investing in them, offering alternatives to cover financing gaps, build infrastructure, and any other activity that may provide them with financial returns. Therefore, we contend that PHS will also play an active role in the process of financialization of health, turning to financial markets, institutions, and investors to continue operating.

To our best knowledge, the only work so far that has employed the concept of financialization to examine changes in the internal structures of a PHS is Bayliss' (2016) seminal work on the English National Health Service (NHS). The author demonstrates how a number of policy shifts in the NHS taking place since the 1990s have brought the system closer to global financial corporations and circuits of financial accumulation. One particularly important mechanism of financialization in this case was the outsourcing of NHS services to private health providers, several of them now owned by investment funds. Another development that brings major consequences to the system is the use of Private Finance Initiatives to build and expand hospitals. In both cases, these mechanisms allow part of the system's resources to end up in the hands of financial companies and investors. It also allows public services and infrastructure to serve as the basis for the creation of private assets owned by financial companies and traded in financial markets.

Considering that both PHS reforms and financialization trends are far from over, the connection between these processes represents a promising and valuable avenue of investigation. A number of tasks would allow us to gain further understanding of how these systems are transformed in light of the process of financialization. In particular, it seems necessary to engage in a more in-depth theoretical discussion on how to conceptualize the financialization of PHS, devise a research method for this specific object, and apply this method to observe empirical developments in different countries.

Theoretical framework

The main hypothesis of this work is that PHS will be reshaped by financialization in ways that support the expansion of the financial sector and the accumulation of financial capital. This hypothesis is informed by two strands of research.

The first is Lavinas (2018b), who studies the impacts of financialization on social policies and social protection systems. Social protection systems are arrangements that integrate different areas of social policy under a common institutional and regulatory

framework. They usually encompass benefits in cash and in-kind provided by the public sector seeking to provide income security and access to health care for the individuals of a country (United Nations, 2018). In practice, it appears in the form of a nationwide system that covers the areas of public health care, pensions, and assistance benefits, sometimes referred to as a "Social Security system" (especially outside Anglo-Saxon countries, where the term is mostly attached to public pensions).

Lavinas' study is based on a historical review of the forms, contents, and objectives of social protection from the past century up to the present financialized stage of capitalism. Following the framework laid out by the French regulation school, the author shows that each regime of accumulation can be associated with a distinctive *paradigm of social protection*, which is functional to the regime in place. In each paradigm, the logic of social provision – its rhetoric, instruments, and goals – would conform to the conditions of economic production and social reproduction in each stage of capitalism, in ways that support the continuous accumulation of capital.

The distinguishing feature of this work is extending the analysis of the mutations of social policies up to the period of financialization, pointing to the rise of a particular paradigm for social provision in the stage of financialized capitalism. The author contends that, in this stage, social provision tends to be reshaped according to the features of a financialized economy, favoring financial accumulation. This process could be seen as the State constrains universal public provision, on the one hand, and facilitate individuals to access essential services, acquire goods, and invest in life opportunities through financial institutions and instruments, on the other. According to the author, this is part of a reconfiguration of the social policy paradigm from the provision of universal services to the granting of cash transfers for individuals and collateral for financial institutions. Such a paradigm would provide individuals with the means to access credit and financial instruments while also securing profits for financial capital. In other words, the State would also facilitate and encourage individuals to use credit and financial instruments as a way to access, via private markets, what public provision fails to offer (see also Lavinas, 2020, 2018b).

Health care is one of the chief sectors of social policies and, accordingly, PHS are one of the core pillars of national systems of social protection. Therefore, departing from the idea initially formulated by Lavinas in the case of social protection systems more broadly, there is reason to infer that PHS would also be undergoing transformations that fit financialized capitalism and favor financial accumulation. Although social protection and national health systems are strongly intertwined, the fact that the latter work in specific ways, much different from other spheres of social protection such as pensions or welfare assistance, requires tailored investigations to apprehend how these transformations will unfold in this case.

The hypothesis that financialization will change the internal workings of PHS finds further support in the literature on State financialization, dedicated to examining how this process redesigns State action (Chiapello, 2017; Karwowski, 2019; Pagliari and Young, 2020; Schwan et al., 2020; Wang, 2015, 2020). The term "State" is used in reference to the

public sector more broadly, including central and local governments, social security agencies, local governments, State-owned enterprises, and sovereign funds, among others. The financialization of the State represents one of the most flourishing areas of research within the contemporary scholarship of financialization (Mader et al., 2020). Karwowski (2019) defines it as the changed relationship between the State and financial markets and practices, with an increasing influence of financial logics, instruments, markets, and accumulation strategies over public institutions and policies. Similarly, Aalbers (2019) describes the "*financialization of the State and (semi) public sector"* as the process through which the *"government, public authorities, education, health care, social housing, and a range of other sectors [are] becoming dominated by financial narratives, practices, and measurements*" (p. 4).

The research on State financialization stands out by showing that, beyond facilitating the expansion of financial markets through regulatory shifts, States and public entities have been actively participating in financial markets and resorting to the financial sector to finance and provide the goods and services still under their responsibility. This can be seen, for example, in instances where welfare state institutions responsible for pensions, housing, education, and health care policies invest in the markets, borrow from them, and subsidize market-based financing (Wang, 2020). Once PHS belong to the public sector and are responsible for funding and delivering public services, this literature strengthens our hypothesis that such systems will be restructured in light of this process.

Research design

Given the absence of a standard approach to examine how financialization reshapes PHS, we will now suggest a way to frame the concept of financialization as an analytical tool to examine developments in these systems. To do so, we first propose a method to conduct our empirical investigation. This method draws from the organizational framework proposed by Karwowski (2019) to investigate the process of State financialization, defined as the increasing influence of financial logics, instruments, markets, and accumulation strategies over public institutions and policies (see the previous section). Karwowski's framework offers a typology of forms of State financialization distinguishing the four main ways through which this process occurs within the public sector. This is the case when public bodies: (i) adopt financial logics; (ii) engage with financial innovations, creating and promoting financial instruments and markets; (iii) deploy strategies for financial accumulation; or (iv) undertake policies that directly financialize the lives of citizens.

The framework described above acknowledges that the policies leading to State financialization may vary significantly from one country to another. It identifies different types of "financialized policies", understood as public policies that allow these developments to come about. In the realm of fiscal policy, this process may appear as a result of policy shifts in both the *revenue side* (how public entities raise funds) and the *expenditure* side (how they spend these revenues). Looking at the revenue side, financialized policies comprise those measures that transform public entities into active market players, leading them to adopt financial instruments and creating or deepening markets for public debt. From

the expenditure side, they include policies that transform public provision into the basis for the creation of financial assets. In the realm of monetary policy, the most common types of policies leading to State financialization consist of inflation-targeting policies, due to their role in avoiding financial asset erosion, and short-term liquidity management policies.

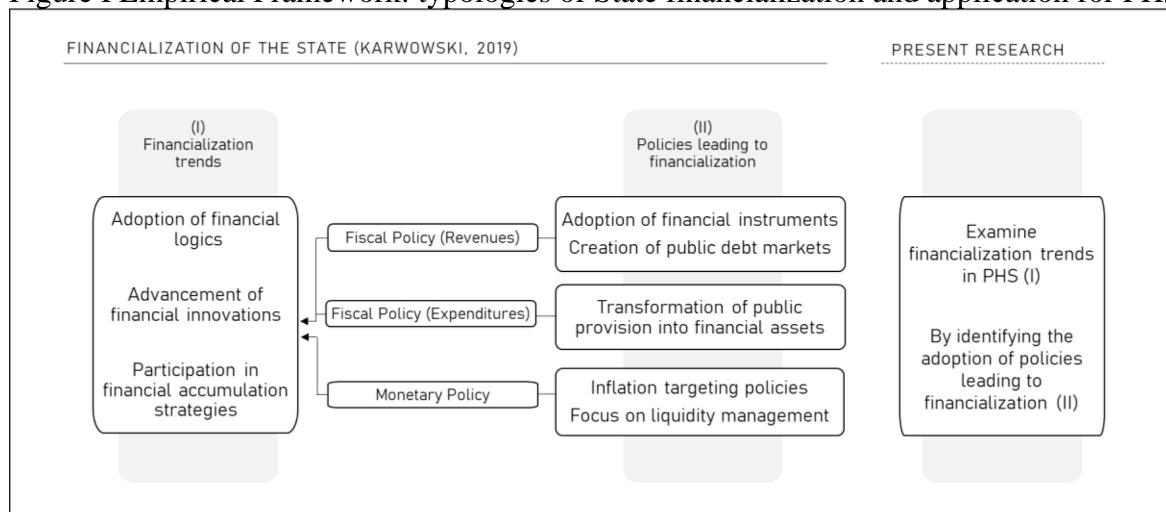
Considering the strong ties between the notions of State and PHS, we can draw from this approach to devise a method to investigate our research object. We offer an initial conceptualization of financialization in PHS as the changed relationship between PHS and financial markets and practices, with the increasing influence of financial logics, instruments, markets, and accumulation strategies in their activities. As detailed later, our goal consists in examining financialized policies leading PHS to (i) adopt financialized logics, (ii) engage with financial innovations, and (iii) contribute to financial accumulation strategies. The fourth expression of State financialization listed in the original framework, "*directly financializing citizen's lives*", is not part of our methodology as our main focus is to investigate how public entities, rather than individuals, will respond to the pressures of financialization.

It should be possible to identify and examine these developments by detecting the adoption of financialized policies that have a direct impact on how these systems work. In the context of our research, financialized policies mean measures that transform the public entities responsible for running the system into financial players or that convert public health provision into the basis for the creation of financial assets. It may also include inflation targeting and short-term liquidity management policies that directly impact the PHS. We use the term financialized policies here in the same sense suggested by Karwowski as policies that facilitate these forms of financialization within the public sector, focusing thus on their outcomes rather than on their content.

The choice for this framework can be justified by the fact that it offers a standardized approach to examine the unfolding of financialization in different contexts. It allows us to investigate the process of financialization across systems that work against markedly different institutional, economic, and political backgrounds using similar criteria, which adds rigor to the research. Moreover, including the fiscal and monetary policy dimensions is particularly appropriate when investigating the financialization of PHS, as both policy fields impact the conditions through which they obtain and spend revenues. We find that the selected framework is comprehensive enough to encompass the different arrangements of monetary and fiscal policies presented by our case studies, while it also offers clear-cut criteria to identify financialization across these arrangements.

Figure I summarizes the main ideas of Karwowski's (2019) typology on typical forms of State financialization and how this will inform our research.

Figure I Empirical Framework: typologies of State financialization and application for PHS



Source: author's elaboration based on Karwowski (2019).

Specifying categories: financial logics, innovations, and accumulation strategies

Due to their relevance as research criteria, it seems important to clarify how we could identify the adoption of financial logics, the use of financial innovations, and the engagement with accumulation strategies by PHS in our empirical research.

First, we consider that PHS adopt financial logics when they follow new criteria in decision-making processes that increase the participation of financial capital in their financing circuits. This includes choices leading to a greater volume of revenues coming from the financial sector or that are invested in the latter.

Second, PHS advance financial innovations whenever they make use of innovative financing solutions backed by financial capital. We are particularly interested in observing the deployment of novel strategies to raise funds that come to replace traditional forms of public health financing, such as taxes, contributions, and government transfers. It should be clarified that the issuance of financial securities by the bodies responsible for the PHS could be considered an expression of the adoption of financial innovations, but this does not extend to the issuance of securities directly by the State (sovereign bonds). This is because the latter serve for general government financing, which includes several areas of which health is but one. Although State securities may be used to finance health spending, public accounting systems make it difficult to precise the amount of marketable debt allocated to this end.

Finally, we interpret that PHS participate in strategies for financial accumulation whenever the systems' revenues are channeled toward financial actors, contributing to the concentration of income and wealth in the financial sector. This is likely to be the case when revenues from the system are used to pay for financial expenditures to banks and investors, such as interest payments and other forms of financial compensation.

The developments described above – the adoption of financial logics, instruments, and strategies – are not mutually exclusive. On the contrary, they often go together. For example, the adoption of financial criteria may favor the resort to financial instruments to

raise funds, and this can contribute to processes of financial accumulation. However, this may not always be the case. Distinguishing these three sorts of developments can thus help to better examine different processes of financialization across PHS. For example, if a system uses financial securities to raise revenues, the idea of engaging with financial innovations predominates; even if this decision reflects the embracing of financial logics and may contribute to financial accumulation, there is still a counterpart in some form of previous lending to the system. If, however, a system channels funds to the financial sector without having received any upfront financing, this is better characterized as a process through which it contributes to financial accumulation strategies.

Working hypotheses and research goals

Our central hypothesis on the relation between financialization and the restructuring of PHS can be broken down into three working hypotheses. First, we infer that the process of financialization has been reshaping how PHS operate, with an increasing participation and influence of financial instruments, actors, and interests in their activities. Second, we claim that the State plays an active role in setting up and promoting this process. Third, we contend that the financialization of PHS is at odds with the foundational principles of these systems, undermining their capacity to fulfill the roles for which they were created.

Considering that PHS follow distinctive arrangements in each country and function within unique social, political, and economic backgrounds (Bayliss and Fine, 2020), case studies seem the most appropriate way to capture the complexity of the phenomenon we seek to apprehend. Therefore, to investigate these hypotheses, we combine a theoretical discussion with an empirical investigation of two countries with universal public systems, France and Brazil. The justifications for choosing these countries are presented in the following section.

We follow the methodological framework outlined above to study the trajectory of the PHS in each country over the past three decades. Our goal is to examine the implementation of financialized policies in each system, meaning policy shifts leading them to adopt financial logics, engage with financial instruments, and participate in financial accumulation strategies. First, we reassess the path of transformations in fiscal and monetary policy in each country from 1990 to 2018 to identify policy shifts that have led to such developments. The choice for this period is justified as the 1990s decade marks the beginning of the era in which both the processes of neoliberal reforms in PHS and the financialization of the world economy accelerated (André and Hermann, 2009; Fine and Saad-Filho, 2017). We then follow a mixed-method approach combining quantitative and qualitative information to examine the most significant shifts that stand out in our investigation.

We focus on investigating policy shifts in financing, which includes not only the volume of revenues entering the system but also who provided them, and at what costs and conditions. This is the most straightforward way to apprehend how financial capital has been increasing its participation and influence within PHS. The dimension of financing is critical for the study of health care systems (Rothgang et al., 2005; Rothgang, 2010a) as well as for understanding how the public and the financial sectors become increasingly intertwined

(Chiapello, 2017). We organize our discussion by systematizing the advance of financialized policies in the three key areas: long-term financing (strategies that affect the system's financing over the years), short-term financing (strategies for managing funds within the fiscal year), and the financing of service providers (strategies to fund hospitals working for the system).

Data sources and adjustments

We use quantitative data to assess the volume of revenues exchanged between the PHS and the financial sector in each country and area under investigation (long-term, short-term, and hospital financing). We seek to provide estimates for the amount of revenues borrowed from, invested in, or channeled to financial actors. The indicators used to examine each country and dimension vary, which is expected given the specificities of the processes of financialization in each case. There are challenges in obtaining data for certain types of transactions involved in PHS financing, especially those that are closely linked to financial institutions and markets. In these cases, information is often unavailable or inconsistent. This seems to be related to both the innovative nature of mechanisms of financialization in PHS and the limitations of public information systems. When facing these types of challenges, we added qualitative information to support and refine the results obtained from quantitative analyses.

The primary sources of information are official public sources, including publicly available databases, minutes of legislative debates, and reports and financial statements from public administration bodies. These bodies include Social Security and government agencies, national statistical offices, official supervisory bodies, public auditing departments, and monetary authorities. The databases and documents used for each country and financing dimension are mentioned in the corresponding sections and located in the bibliographical references. Further explanations on the sources of data can be found in Appendix 2.

The data for each country is presented in domestic currency, Euro (EUR, €) in France and Reais (BRL, R$) in Brazil. To allow a clearer comparison, we indicate the equivalence between these currencies in the tables for the second case study. Unless explicitly stated otherwise, all figures are in constant values of 2018, adjusted for inflation according to the national consumer price index (Indice des Prix à la Consommation – IPC in France and Índice Nacional de Preços ao Consumidor Amplo – IPCA in Brazil). Adjusting the series for inflation provides a more accurate view of the evolution of the selected indicators over the long run.

All quotations from foreign languages were freely translated by the author.

Case selection

France and Brazil represent a particularly valuable combination to gain further understanding of the process of financialization in PHS. On the one hand, both countries are

committed to providing universal health care for the population. On the other, they are at different stages of economic development and their health systems work differently – one under the logic of social insurance, and the other under the logic of direct service provision.

France is a core country with a health system of the social insurance type. The French system was once considered the best in the world by the World Health Organization (WHO, 2000). At the same time, it also seems to be in the lead when it comes to implementing financialized strategies to run the system, which reach a degree of complexity unseen in other countries. Brazil, for its part, is a peripheral country with a health system of the national health service type. It is one of the few middle-income countries to have a universal system, open to all the population and entirely free at the point of delivery. The Brazilian PHS is considered the largest system in the world in terms of population coverage, as more than 200 million people are entitled to use the system. Its creation at the end of the 20th century represents a milestone in the history of public health, going against worldwide trends toward restricting public intervention taking place at that time. Nevertheless, the attempts to consolidate the system took place when neoliberalism was already in full swing. This means that, different from core countries, the Brazilian system was subjected to the pressures of financialization since its early years, and it is of great interest to study how this dynamic will play out.

For the above reasons, this choice of countries gives us a unique opportunity to apprehend simultaneous, yet different trajectories toward financialization. More than a comparative study, it can demonstrate the global reach of the process of financialization in PHS, while also shedding light on the influence of national factors in determining how they will manifest in each case. Also important, it offers insights into how a country's position as a core or peripheral economy may influence how the process of financialization impacts its PHS.

Structure of the thesis

The thesis is organized into four chapters. The first chapter lays out the theoretical framework that informs our discussion, introducing the concept of financialization and showing how it has been used to discuss themes related to our research. After providing an overview of definitions and stylized features of this process, we discuss how financialization has been studied in two areas that are crucial in presenting our findings: first, we explore the literature on the financialization of State activities and social policies; second, we look at the differences between how processes of financialization unfold in central and peripheral countries, with special attention to the French and Brazilian experiences.

The second chapter bridges the gap between the concept of financialization and the existing research on PHS. We begin by providing background information on PHS, describing the path of neoliberal reforms in these systems since the 1980s and the most common terms that have been used to examine them. Based on this review, we elaborate on how the idea of financialization can be introduced as an analytical tool to examine reforms in PHS. We draw from the literature on financialization in the public and health sector discussed in the first and second chapters to conceptualize the process of financialization in

PHS, suggesting what would be the main features of such a movement. We also contextualize the process of financialization within the long-standing path of neoliberal reforms in PHS. We do so by discussing how it relates to other processes that have shaped their evolution to date, namely privatization. We show that the financialization of PHS remains understudied and that this extends to the cases of France and Brazil, where the existing research is yet to look at transformations taking place within these systems.

The third and fourth chapters examine how the French and the Brazilian PHS, respectively, have been reshaped by the process of financialization. The chapters follow a similar structure. The first section features the systems of social protection and public health care in the country and points out the general direction of post-1990s reforms. The second section charts the financing of the PHS, including how it is organized and the evolution of its financial accounts over this period. The closing section examines the mechanisms through which financialization reshaped these systems, distinguishing three dimensions: long-term, short-term, and hospital financing.

In the conclusion, we draw on the theoretical debate and empirical findings of the thesis to discuss our working hypotheses and mention perspectives for further research. We systematize the main findings for the French and the Brazilian cases, making sense of the process of financialization in PHS and reflecting on how national specificities have influenced each path. We then discuss the role played by the State in this process and how financialized strategies have impacted the core principles upon which these systems were founded, namely solidarity, stability, and democratic participation.

Contributions

Our main contribution to the literature comes from reassessing the trajectory of PHS from the fresh theoretical background of financialization, which represents a relatively new approach in relation to the existing literature on health systems change. This allows us to shed light on particular sets of instruments, actors, and interests with a decisive role in past and present developments, but whose influence has remained largely misapprehended. Our research offers one of the first detailed investigations on the influence of the process of financialization in PHS and the first one to conduct a systematic investigation of different countries following the same approach. We look at countries that have never been studied under these lenses, presenting original empirical evidence from data compiled for this investigation. The findings allow us to contest the widespread but mistaken belief that comprehensive systems of public provision are somehow shielded from the process of financialization. At the same time, by tracing markedly different paths of financialization within PHS, we can gain a broader understanding of this phenomenon and its negative impacts on public health financing and provision. We also offer a conceptual and methodological grid of analysis to assess the financialization of PHS that can be replicated for other countries, contributing to a new research field of social and economic relevance.

Limitations

The first limitation of our study concerns the possibility to generalize the results to other countries. Even though our findings can provide important insights to understand how this process unfolds in different settings, the mechanisms through which it occurs in each case can only be fully understood through detailed investigations accounting for national specificities. The same is true for other dimensions of the PHS that we could not incorporate in our research for reasons of space and lack of information.

The second relevant limitation refers to data availability. Especially in the case of Brazil, there were challenges in obtaining high-quality data. These include frequent changes in the methodology for measuring and presenting information, the lack of systematic and rigorous updating of information by public agencies, and conflicting values across different sources of information. When this was the case, we opted for building homogeneous and continued series for short periods and based on the source of information that offered the most consistent series in terms of the methodology used and the type of data available.

CHAPTER 1. FINANCIALIZATION AND ITS PATHS INTO SOCIAL PROVISION

This chapter presents the theoretical framework that informs our investigation, introducing the topic of financialization and how it has been studied in areas that are strategically important to our discussion. The chapter is divided into three parts. In the first part, we review the critical scholarship on financialization, presenting influential definitions of this concept, stylized facts, and how different theoretical strands in Economics have approached the subject. In the second part, we explore how financialization has manifested differently across the globe, describing the paths followed by central and peripheral economies more broadly and the particularities of the French and Brazilian experiences. The final part of the chapter looks at how this concept has been used to examine transformations in social provision across central and peripheral economies – focusing on the provision of public services in areas associated with social rights. We propose an original organization of the existing literature on the topic to show that financialization has been reshaping both sides of social provision: on the one hand, how individuals are accessing essential goods and services, and, on the other, how public entities are financing and providing the latter.

1.1 Finance and financialization

There is a common recognition that we live in an era when financial players are influencing events beyond their traditional spheres of operation, to a degree unknown until the late 20th century. The acknowledgment of this trend is at the heart of the current usage of the term "financialization", which encapsulates the increasing role of globalized finance into ever more areas of economic and social life (Fine and Saad-Filho, 2017).

The onset of the financialization of the world economy is usually associated with the liberalization of capital flows and the integration of financial markets following the end of the Bretton Woods system in the 1970s. The continuous development of new technologies and financial innovations, as well as the consistent promotion of regulatory changes at the domestic and international levels favoring the financial sector, helped to further increase the volume and speed of financial flows during the following decades (Chiapello, 2019; Guttmann, 2016).

Although its origins are obscure, the term "financialization" started to appear with increasing frequency in the 1990s and underwent a boom in the 2000s (Foster, 2007). This was when a thematically coherent body of academic work from various disciplines engaged with the phenomenon sparked off (Erturk, 2020). The number of journal articles with "financialization" among the keywords has more than quadrupled between 2000 and 2018, which illustrates the growing relevance of the term for academic research (Mader et al., 2020). Despite its increasing popularity and widespread use, there is no universally accepted definition for the concept of financialization.

Perhaps most famously, Epstein (2005) defines it as "*the increasing role of financial motives, markets, actors, and institutions in the operation of the domestic and international economies*" (p. 3). Aalbers' (2019) alternative version of this definition, introduced at the beginning of this thesis and used as our reference point, has expanded the scope of this process to include other dimensions of social and political life. For the sake of clarity, we will repeat it here: "*the increasing dominance of financial actors, markets, practices, measurements, and narratives, resulting in a structural transformation of economies, firms, States, and households*" (p. 4).

Along with these broad definitions of financialization, the literature also offers narrow interpretations of this process. They include, for example, the understanding of financialization as "*a new form of competition which involves a change in [the] orientation [of firms] towards financial results*" (Froud et al., 2000, p. 104) or a "*pattern of accumulation in which profit-making occurs increasingly through financial channels rather than through trade and commodity production*" (Krippner, 2005, p. 181). Broad and narrow notions of financialization are mostly in agreement; in general, the latter is concerned with specific phenomena encompassed by the former (Mader et al., 2020).

The lack of a commonly agreed meaning is not accidental. From a theoretical standpoint, the academic debate on the topic is large and diverse. It comprises works from different scientific backgrounds and which look at the implications of financialization over a wide range of topics (Mader et al., 2020). In practice, the process of financialization exhibits considerable variation across countries and sectors (Bayliss et al., 2016a; Fine, 2014; Lavinas, 2017). In light of this diversity, it is neither possible nor useful to seek a universal definition of the term (Golka, 2019; Lapavitsas and Soydan, 2020). A more valuable task is to use this rich discussion to develop an analytical framework upon which we can better understand present-day developments in the PHS.

Beyond their differences, all of these definitions converge to the understanding of financialization as a three-sided process involving the growing size of finance in the global economy, its expansion in scope, and its progressive concentration of wealth and power relative to other actors (Gabor, 2018). But what is actually expanding, and how? In the literature on financialization, it is common to find studies that address the topic without first specifying what allows something to be labeled as "financial", who are financial actors, what activities they engage in, through what instruments they make profits, and how they can gain power over other actors. Without intending to carry an exhaustive analysis of these topics, addressing these questions will allow us to clarify later how the concept of financialization can contribute to the research on PHS.

1.1.1 Finance and its workings: the conventional view

In dictionary definitions, the term "finance" appears in at least three correlated ways: (i) the system allowing for the provision and management of funds in an economy, based on a wide array of activities such as the circulation of money, the granting of credit, the making of investments, and the provision of banking facilities; (ii) the scientific field dedicated to

the study of such activities; and (iii) the volume of funds available for undertaking a certain action (Oxford University Press, 2006; Merriam-Webster Dictionary, 2021).

The Swedish International Development Cooperation Agency (SIDA) offers a technical yet informative description of the financial system, including its actors, instruments, and markets, as well as of the broader structure upon which they work. As explained by the agency,

> **The financial sector** forms the structure of arrangements in an economy which facilitates the conduct and growth of economic transactions through the use of money for payments, savings, and investments. It **consists of financial policies and financial infrastructure which support the financial system (institutions, instruments, and markets)**. (…)
>
> As to **financial institutions** they include: (…) financial intermediaries such as banks, microcredit institutions, rural and informal finance institutions, pension funds, insurance companies, leasing companies, risk capital funds and other specialized institutions; financial facilitators such as brokers, credit information agencies, and rating agencies.
>
> **Financial markets** comprise money markets ([for] short-term debt instruments) and capital markets ([for] equities and long-term debt instruments).
>
> **Financial instruments** represent claims to real resources, and they may consist of demand and time deposits, bank loans, bonds, debentures, certificates of deposits, and shares (SIDA, 2004, p. 4, emphasis added).[3]

The conventional, mainstream approach to finance is heavily grounded in the "functionalist" perspective of the financial system (Bodie and Merton, 1995; Crane et al., 1995; Merton, 1995). According to this perspective, the financial system serves six functions in an economy: (i) organizing a payment system for the exchange of goods and services; (ii) providing mechanisms for pooling funds; (iii) transferring economic resources through time and across geographic regions and industries; (iv) setting up devices for risk management (such as hedging, diversification, and insurance); (v) disclosing information that helps in decision-making processes; and (vi) addressing incentive problems arising from asymmetric information.

This view of finance has been largely embraced by neoclassical economists. Not only do they tend to agree with this functionalist perspective, but the assumptions of neoclassical theory lead them to see the financial system as intrinsically efficient and the individuals who participate in it as rational agents. Accordingly, the financial system is described as a self-balancing mechanism serving to optimize resource allocation (Karwowski and Stockhammer, 2017; Lavoie, 2014; Tadjeddine, 2018). It is seen as a neutral place of exchange where financial institutions play the role of intermediaries connecting those who have money (savers) and those who need it in order to invest in production (Chambost et al., 2018; Davis and Walsh, 2017; Rowden, 2019), with no impact on the "real" economy (Guttmann, 2016). As summarized by Guttmann (*op. cit.*), "*the standard neoclassical*

[3] In the original report, the agency also includes financial institutions from the public sector such as central banks. For the purposes of this discussion, we excluded them from our concept of financial institutions, the reason being that we seek to examine how private finance is being incorporated into public financing circuits.

approach divides the economy into 'real' and 'monetary' spheres and keeps finance reduced to a passive residual connecting savings to investments, via a process of intermediation organized by financial institutions and markets" (pp. 65-6).

1.1.2 Finance from a heterodox perspective

The neoclassical approach to finance is heavily criticized by heterodox economists. The Heterodox tradition encompasses a variety of schools of thought sharing fundamental principles and premises that differentiate them from mainstream neoclassical theory. These include the search for realistic assumptions and explanations of real-world phenomena, the consideration of individuals as social beings (influenced by habits, conventions, norms), and the rejection of the assumption that markets alone can lead to the best possible economic and social outcomes, to name a few (Lavoie, 2014). Such principles render the heterodox approach much more apt to explain the current size and roles of the financial system.

Each heterodox school examines economic and social developments from a particular angle, leading to a multifaceted critique of the mainstream view of finance. Several reviews (Epstein, 2018; Hein et al., 2015; Karwowski and Stockhammer, 2017) suggest that post-Keynesians, for example, tend to focus on issues of fundamental uncertainty and non-rational behavior, demonstrating how they undermine the supposed efficiency of financial markets; Marxists, in turn, pay greater attention to asymmetries of power and how finance deepens and multiplies them; and French regulationists, for their part, emphasize the influence of institutions (organizations, conventions, and rules more generally) in shaping the interactions at play.[4] However, there is not usually a conflict between these views; on the contrary, they are often combined to form a more general critique of finance. Given the broad common ground shared by heterodox theories, scholars from different strands tend to draw upon each other's ideas to develop a critical analysis of the financial system.

While each school may frame differently the economic and social issues associated with financial markets, there is a widespread consensus that the financial system does not work simply as a neutral place of exchange. In light of real-world evidence, heterodox scholars suggest that the conventional view on finance reflects a limited understanding of the purposes of financial activities and the power of financial institutions today. To understand the essence of the heterodox critique, it is useful to point out one crucial aspect of finance, largely underestimated by the mainstream view; the system's capacity to organize the transfer of revenues and risks across time, space, and agents. The ability to break temporal and spatial constraints is important because it allows wealth to be created on what is yet to be produced, this process of anticipation being a key factor in allowing for the expansion of the financial system (Durand, 2017).

Krippner (2005) suggests that future expectations are at the very essence of financial activities and profits. In this influential paper, the author defines financial activities as "*activities related to the provision or transfer of liquid capital in expectation of future*

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[4] Some works present the French Regulation School as part of the Institutionalist School, although this is a matter of debate (see, e.g., Boyer, 2003; Lavoie, 2014).

interests, dividends, or capital gains" (p. 174). In a similar vein, Sarlat (2009) contends that all goods, currencies, and capital traded on financial markets are judged according to their present value and by the future income they are likely to bring; in this way, "*by buying and selling products on the financial markets, we are (...) buying and selling future income*" (p. 543). To give concrete examples, loans and bonds, for example, represent claims on the repayment of the principal and interests by the borrower in the future. In a similar vein, equity securities (e.g., company shares) guarantee rights to part of the future earnings and assets of another entity. Pushing the argument further, Weber (2020) argues that any financial instrument, whatever the final form it assumes, is first and foremost a "promise to pay": savings accounts, demand deposits, shares, bonds, derivatives, and others, could be similarly characterized as "*contracts wherein an issuer promises to pay money at some future date under specified conditions*" (p. 459).[5]

Such characteristics of the financial system – a network of interconnected institutions, markets, and instruments linking productive and monetary circuits, separating them in space and time, and breaking financial constraints at the individual level – could open windows of opportunity for speculation and resource accumulation in the financial sphere.[6] As reminded by Guttmann (2016), in contemporary economies, all economic activities are organized as interdependent monetary circuits. In this context, and given such properties, the financial system could serve as a way to finance production, but it could also create alternative investment opportunities *in lieu of* production. Said otherwise, it would allow, at least in part, for the use of financial instruments to reap gains disconnected from the financing of productive activities. Still according to the author, in finance-led capitalism, the activity of accumulating financial assets for income generation in the future becomes central, with finance organizing the proliferation of such financial investment channels. Some of these channels would yield income as compensations from previous lending, such as with interests; others would enjoy relative autonomy from the so-called "real economy" of production and exchange, which is mainly the case of capital gains from speculation with price movements in financial markets. These developments are embodied in the concepts of "interest-bearing capital" and "fictitious capital", respectively.

The concepts of interest-bearing and fictitious capital have been discussed by Marx (1894) and are frequently used by heterodox economists to make sense of contemporary processes of financial expansion and accumulation. Interest-bearing capital could be explained as capital that is lent and remunerated through the payment of interest. It may or may not generate fictitious capital, which generates revenues from the anticipation of the capital valorization process (Durand, 2017). Guttmann (2016) offers a synthesis of this second (and much trickier) concept:

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[5] It is interesting to note that the idea of a "promise to pay" is at the origins of the own term "finance". According to Cresswell (2010), the roots of the English term finance can be found in the Old French *finer*, "*the payment of a debt, compensation, or ransom*", from the Latin *finis*, "*to end*". Szendy (2020) draws attention to the fact that the etymology of *finance* is closely related to that of *fine*, which means "*to punish (a person) for an illegal or illicit act by requiring him or her to pay a sum of money*".

[6] Speculation denotes the purchase or sale of something for the sole purpose of making a capital gain, irrespective of the underlying activity generating the investment. The goal is obtaining profit from the variation of prices or other variables, without the intention of keeping the investment for long.

> (…) fictitious capital involves the trading of claims in financial markets especially created for their circulation. Their value has no material basis in production (hence is "fictitious") and rests instead on the capitalization of future income their holders anticipate. (…)
>
> While the notion of fictitious capital dates back a century and a half, it has not lost its relevance today. In the era of finance-led capitalism we have witnessed an amazing proliferation of tradable financial claims, which investors trade for capital gains (…) these are objects of speculation by investors seeking to profit from their trading without direct connection to the underlying monetary production economy; hence arguably this is fictitious capital. (pp. 69-70, 72)

The accumulation of wealth via interest-bearing and fictitious capital has been at the heart of heterodox explanations for the unbridled expansion of financial activities over the past decades, even if the weight accorded to each of these forms of capital varies from author to author (see, e.g., Durand, 2017; Fine, 2013; Guttmann, 2016; Lapavitsas, 2013). Bearing these elements in mind, it becomes easier to understand the heterodox critique of finance's supposed neutrality and the claim that, on the contrary, it has a key role in determining real-world events. They can help explain how finance has served as a channel for the appropriation of a rising share of global income in ways that are largely disconnected from real-world developments.

Together with the recognition that the purposes of financial activities go beyond financing production, another fundamental distinction between the conventional and heterodox approaches to finance concerns how they perceive financial actors. Heterodox scholars claim that financial institutions play roles that go far beyond the intermediation between savers and investors, having a systemic power over the global economy (Durand, 2017; Guttmann, 2016; Tadjeddine, 2018). Emphasis is placed on those actors at the top of the "financial pyramid", who run and control the financial system. These include banks, insurance companies, and investment funds such as hedge funds and private equity funds, to name a few. It is also common to mention the wealthy individuals who rule the system and whose property materializes in the holding of financial assets as part of this center of power (see, e.g., Chesnais, 2016; Duménil and Lévy, 2004; Guillen, 2014).[7]

The power held by financial institutions in today's capitalist economies can be understood in light of the privileges they hold in contemporary economies. On the one hand, they have the capacity to create money and organize investment circuits; on the other, they have an unparalleled ability to undertake and influence investments in these same circuits (Guttmann, 2016). Such prerogatives and powers would grant financial players with an unprecedented capacity to "*make money from money*" (Mulligan, 2016, p. 47) for themselves and others, multiplying the funds they manage through loans, investments, and speculation in financial markets (Appadurai, 2015; Chesnais, 2016).

[7] The heterodox literature often employs the term "financial sector" with an implicit meaning, referring to these largest players with a systemic power to influence developments in the sector and in the economy more broadly. Following this view, we employ the terms "financial sector", "finance", "financial institutions", and "financial actors" interchangeably in reference to those agents. We also use the concept of "financial capital" broadly as the volume of funds they manage.

The heterodox critique on the idea of finance's neutrality is backed up by empirical evidence. It is virtually impossible to obtain precise figures on the volume of financial assets and the size of the financial sector at the global level due to several factors related to complexity and lack of transparency. A significant share of financial transactions occurs in the so-called "shadow banking" sector – a set of highly heterogeneous entities and activities lying outside the regular banking system (Financial Stability Board, 2018), poorly regulated and monitored. Still, figures for regulated activities only can already give a sense of the disproportionate evolution of the financial sector relative to the "real economy". According to estimates from McKinsey (2005), the value of global financial assets increased more than tenfold between 1980 and 2005, from around US$12 trillion to 118 trillion. Comparing it to the size of the global economy (measured by the gross domestic product), the global stock of financial assets has more than tripled in this period, from 110% to 325% of the world's GDP.[8] More recent estimates from Macquarie Research (2017) trying to incorporate at least part of the "shadow banking" sector describe a rise in the value of global financial assets from approximately 2.6 times of the world GDP in 1990 to more than five times in 2016. One of the latest data available to date indicates that the total value of global financial assets reached nearly US$380 trillion in 2018, with the value of domestic assets representing on average six times the national GDP in high-income economies and three times in middle-income ones (OECD, 2020).

The soaring value of financial assets has been accompanied by a dramatic growth of the institutions that create, manage, and profit from them. Assessments of the world's largest companies suggest that the financial sector outperforms all other sectors in terms of retained wealth and profits, surpassing even sectors such as energy and technology (Forbes, 2019). Forbes' ranking of the 2,000 largest listed companies of 2019 shows that financial companies (banks, insurance companies, and other financial companies combined) represented more than a quarter of entries, making finance the sector with the largest number of companies on the list. Together, these companies reaped over US$12 trillion in profits this year, more than double the amount earned by the second most profitable sector, occupied by oil and gas companies (Ponciano and Hansen, 2019). Equally impressive is the observation that, today, each one of the world's largest asset management firms has a volume of assets under management worth more than the GDP of several countries (Epstein, 2019; Plihon, 2019).

In light of this evidence, examining the hegemony of finance today requires questioning the legitimacy of the economic rents received by these actors and the true nature of the services they provide (Tadjeddine, 2018). This investigation is at the heart of the research field of financialization.

1.1.3 The academic scholarship on financialization

There is today a solid body of research attentive to the growing dominance of finance and its impacts on the social, economic, and political spheres. We refer to this line of research as the critical literature on financialization (see definitions at the beginning of this chapter).

[8] This value of financial assets encompasses "traditional" instruments only – bank deposits, government bonds, private debt securities, and equities. Nominal values.

It encompasses studies from different scientific fields, including Economics, Anthropology, History, Geography, Sociology, and Political Sciences (Mader et al., 2020; Van der Zwan, 2014). Within the field of Economics, the financialization debate is led by the heterodox approach, notably by authors from the Marxist, Post-Keynesian, and French Regulationist schools (Hein et al., 2015; Karwowski and Stockhammer, 2017; Lapavitsas, 2011).[9] This diversity can be regarded as a strength rather than a weakness of the financialization literature; combining various streams of scientific research allows for a deeper comprehension of the object under investigation, as each discipline can highlight aspects that others are less inclined to grasp (Mader et al., 2020).

Authors from different schools tend to inspire and conceptually borrow from each other when defining and featuring the process of financialization (Hein et al., 2015; Karwowski and Stockhammer, 2017; Mader et al., 2020). As concluded by Hein et al. (*op. cit.*), "*when it comes to the main characteristics of the financialization period, we see some convergence among different approaches, and no fundamental differences but some complementarities*" (p. 50). This overlap between schools of thought justifies our choice to combine authors from different theoretical backgrounds when defining and characterizing this process.

Some fundamental traits unite this seemingly heterogeneous array of works and justify its unification into a single body of research. Most importantly, financialization studies depart from a view of finance beyond its traditional role as a provider of capital for the productive economy; instead, they consider the increasingly autonomous character of global finance and how this alters the underlying logics of the economy, politics, and society (Van der Zwan, 2014). The financialization literature has a critical view on the size of the financial sector as well as the volume and complexity of financial transactions and assets across the economy, associating them with detrimental impacts on financial stability, growth, and income equality, among others (Karwowski, 2019).[10]

Financialization studies focus on examining at least three intertwined phenomena: (i) the shifting relationship between finance and other economic sectors, with the increasing importance of the former and its associated class group (the "rentiers"); (ii) the changes taking place within the financial system itself, such as the growing importance of financial markets, the evolution of banks, and the sophistication of finance through innovations of products and practices; and (iii) the increasing magnitude of finance, with the decoupling from its earlier functions and logic (Ramos, 2017). We can argue that, beyond the shifting relationship between finance and other economic sectors, financialization studies look at several domains that extend to different agents (e.g. non-financial corporations, households, public sector entities), markets (e.g., commodity, energy, food, and labor markets), policy

[9] Reference to the French regulation school sometimes appears implicit in mentions of the institutionalist school (see footnote 4).
[10] In line with this view, Mader et al. (2020) list three key affinities shared by financialization scholars: (i) the recognition of finance as not subservient to the productive economy, but as an autonomous realm that increasingly influences and dominates other dimensions; (ii) the critical stance regarding such expansion and emancipation of finance, linking them with negative socio-economic and political developments; and (iii) the denial of the mainstream view of finance, which studies it as a primarily economic issue, articulating changes in finance with shifts in politics, economics, social relations, and culture.

fields (e.g., housing, education, health care, and environmental policies), and geographical areas (e.g., central economies, emerging countries, post-soviet countries).

Several works have sought to make sense of this rich literature on financialization by mapping subfields of research. The most cited systematization so far is arguably the one proposed by Van der Zwan (2014), who distinguishes existing studies into macro-, meso-, and micro-level approaches. According to this view, macro-level studies look at the capitalist system more broadly and examine financialization as a new regime of accumulation. They are concerned with structural shifts in the patterns of capital accumulation, the evolution of macroeconomic aggregates, and the empowerment of the "rentier" class. Meso-level studies focus on transformations at the firm level, considering financialization as a distinctive behavioral pattern of modern corporations prioritizing shareholder value maximization. They investigate the reorientation of investment expenditures by these firms and redistributive processes between managers, shareholders, and employees. Finally, micro-level studies are most interested in individuals and households, with financialization associated with a transformation in "everyday life". This transformation is perceived through a wide range of shifts, from a cultural revolution that leads them to perceive themselves as investors to concrete events through which they are treated as such.

For a better characterization of this debate, we can list a number of "stylized facts" identified by the literature when examining the process of financialization. These can be understood as consistent empirical findings that, although not always present, are regular enough to characterize this process. Bringing together comprehensive reviews on the subject (Ashman and Fine, 2013; Hein and Treeck, 2010; Stockhammer, 2008), we can say that the process of financialization has been often associated with (although not limited to) the following trends: (i) the growth of the financial sector in the economy, including the share of financial activity as a proportion of total economic activity and of financial profits as a share of total profits; (ii) the increasing importance of financial activities for non-financial firms, with traditionally non-financial firms engaging with financial investments and earning a larger share of their revenues from the latter; (iii) changes in investment patterns, with the decrease in the overall levels and returns of real investments compared to financial ones; (iv) changes in the governance of firms, with the prioritization of shareholder value maximization (the increase in the volume of revenues addressed to shareholders, often at the expense of reinvesting profits or increasing wages and workforce); (v) a surge in speculative activities by financial and non-financial entities; (vi) the decline in real wages and the wage share; (v) mounting levels of household, corporate, and public debt; (vii) increasing income inequality arising out of greater financial rewards along with lower real wages; (viii) the slowdown of economic growth; (ix) higher levels of financial instability and frequency of economic crisis; (x) shifts in the structure of public revenues and expenditures.[11] This last aspect is of particular relevance for this thesis and will be explored in greater depth later in this chapter, since it directly influences the financing of PHS by defining how and how much they receive in revenues.

[11] It is important to note that these are general tendencies; as we will see throughout the chapter, they do not necessarily have to be present all at the same time to characterize the financialization of an economy.

Having presented the concept of financialization and summarized key points from the literature, it is important to clarify where exactly lies the originality and contribution of this scholarship. We begin by identifying what is not new; the recognition of the importance of financial activities and their expansion in overall economic activity. It is well-recognized that individuals have been engaging with financial transactions and instruments since the beginning of recorded history, with creditor-debtor relationships organizing social life for many centuries before the emergence of capitalism (Bodie and Merton, 1995; Graeber, 2011; Lazzarato, 2012). Similarly, there are long-standing debates on the facts that financial markets seem to follow a unique and to a certain extent autonomous behavior in relation to other markets (Keynes, 1936; Marx, 1894) and that the financial sector tends to outgrow other sectors at certain points of capitalist cycles (Arrighi, 1994).

The contemporary theory of financialization distinguishes these processes, temporally and spatially bounded, from the changes in capitalist accumulation taking place today (Bonizzi et al., 2020; Powell, 2018). The current meaning of financialization designates not simply the existence of financial relations or a quantitative phenomenon associated with the growth of the financial relative to the productive sphere, but a qualitative transformation in the pattern of capital accumulation (Guillen, 2014). Scholars working with the notion of financialization argue that, in contrast with previous historical periods, the last decades have seen finance not only expand but also determine developments outside of the financial sphere, including patterns of economic production, social reproduction, and resource distribution. These qualitative transformations justify framing the present phase of capitalism as a distinctive stage *underpinned* or *dominated* by finance (Fine and Saad-Filho, 2017). Put bluntly, in contrast to previous moments, developments in finance would now contribute to the formation of a new stage of capitalism.[12] Within this transformation, finance plays a catalytic role in the extension, expansion, and intensification of capitalist accumulation, while increasing opportunities for exploitation and expropriation (Bonizzi et al., 2020).

While there may be some opposition to the use of the term "financialization" (Christophers, 2015; Fine and Saad-Filho, 2017; Amable et al., 2019), the idea of a distinctive era of capitalism subjected to the power of finance seems much less contested by the academic community.[13] This can be illustrated by the myriad of terms coined by scholars from different theoretical schools reflecting this idea: we can mention the notions of "*finance-dominated capitalism*" present by post-Keynesians (Hein, 2012; Stockhammer, 2008); the discussions on "*capitalism underpinned by financialization*" and "*financialized capitalism*" carried by authors within the Marxist framework (Fine and Saad-Filho, 2017;

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[12] According to Fine and Saad-Filho (2017), what characterizes a stage of capitalism are the distinctive ways in which the accumulation, distribution, and exchange of value are organized and reorganized, as well as its implications for social reproduction. It follows, then, that the rise of financialization over the past decades would have profoundly transformed such foundations, shaping a new stage of accumulation.

[13] To avoid overgeneralization, scholars underscore the importance of setting boundaries for the use of the term and distinguishing it from other processes that also influence the course of contemporary economies, such as commodification, commercialization, globalization, privatization, digitalization, and work precarization (Christophers, 2015; Mader et al., 2020; Stockhammer, 2008). In the second chapter of this thesis, we will clarify the specific way in which we understand the process of financialization in PHS and differentiate it from other processes with a recognized influence on these systems, namely privatization.

Lapavitsas, 2013); and the idea of a "*finance-led growth regime*" or "*finance-led capitalism*" developed within the French Regulation School (Boyer, 2000; Guttmann, 2016).

Associating financialization with the present stage of capitalism also requires clarifying how this concept is connected to the idea of neoliberalism, the most common term to refer to this stage. Although heterodox approaches follow different criteria to distinguish the stages of modern capitalism, Fine and Saad-Filho (2017) identify some uniformity in the periodizations proposed by them: a *laissez-faire* period in the 19th century giving way to a more monopolistic stage in the first half of the 20th century, followed by an era of active and explicit State intervention around the post-war period, and a neoliberal stage emerging from the 1980s on. While it is impossible to do justice to the entire discussion on neoliberalism, these authors suggest that the term can be understood as a set of economic and political ideas, and a set of policies, institutions, and practices accompanying these ideas, in favor of private capital in general and financial capital in particular.[14] These would be articulated through the power of the State to impose, drive, underwrite and manage the internationalization of production and finance in each territory, often concealed under the narrative of non-interventionism. In this way, the neoliberal paradigm would set the context for the continuing expansion of finance in scale and power (that is, for financialization), which in turn strengthens the paradigm in place.

1.2 Together but different: financialization in central and peripheral countries

Although the process of financialization is global in nature, there are no two countries in which it manifests in the same way (Aalbers et al., 2020). Therefore, it is critically important to consider the specificities of each case under investigation to apprehend the variegated nature of financialization across the world (Bayliss et al., 2017; Fine, 2013).

1.2.1 Distinguishing central and peripheral financialization

The early research on financialization focused on individual countries, with a strong emphasis on Anglo-Saxon economies – the United States and, to a lesser degree, the United Kingdom. This has encouraged a biased approach in examining other countries, leading to the misconceived idea that there is some sort of "standard" financialization model that could be used to address other experiences (Aalbers et al., 2020; Karwowski et al., 2020). Over time, this has lost ground to a more inclusive approach that investigates other settings taking into consideration the social, spatial, economic, political, and historical context. This new perspective demonstrated that financialization is not restricted to a few countries nor that there is a unique model of financialization that can apply to them all (Aalbers et al., 2020; Bonizzi, 2013; Massó et al., 2020).

[14] For well-grounded syntheses of the ways in which the term "neoliberalism" has been employed in social sciences and its relations with the idea of financialization, see Fine and Saad-Filho (2017) and Davis and Walsh (2017).

A common way to make sense of different paths of financialization without losing sight of its global character is to contrast the experiences of central and peripheral countries.[15] Gaining awareness of the typical features of financialization in each of these groups helps to better examine how this process unfolds in France and Brazil, positioned in the center and the periphery of capitalism, respectively.

The research distinguishing financialization in central and peripheral economies has greatly expanded our knowledge on the theme by unraveling the influence of domestic and foreign pressures in shaping national experiences (Becker et al., 2010; Bonizzi et al., 2020; Karwowski et al., 2020). In the case of central economies, studies acknowledge a number of commonalities that include, first and foremost, the significant weight of domestic factors in driving processes of financialization. In one of the most recent and extensive studies on the topic, Karwowski et al. (2020) find that the three key factors driving financialization in core countries have been asset price inflation, financial deregulation, and debt accumulation, which corroborates the importance of domestic phenomena (see also Bortz and Kaltenbrunner, 2018; Karwowski and Stockhammer, 2017; Stockhammer, 2008).

Studies for peripheral countries, in contrast, emphasize the role of external forces in driving this process. According to Bonizzi (2013), "*peripheral countries are subject to shifts similar to those experienced by core countries, but at the same time these are mediated by their subordinate position, which determines how financialization takes place*" (p. 86). The recognition of a distinctive dynamic of financialization directly shaped by the relations with the most industrialized nations has informed the literature on "subordinate" (Bonizzi et al., 2020; Powell, 2013) and "peripheral" (Becker et al., 2010) financialization. Both approaches share considerable common ground in which they stress the derivative character of financialization in the periphery of capitalism – that is, shaped by financialized activity in the center (Karwowski, 2019; Lapavitsas and Soydan, 2020).

To make the distinction between domestic and external drivers of financialization clearer, we can provide concrete examples of the factors shaping this process in the periphery. These factors include, in particular, the subordinated position that these countries occupy in the circuits of global trade and the international monetary system. This positioning would determine the behavior of capital flows, the global hierarchy of currencies, the influence of international and foreign financial institutions on domestic policies, and the quest for accumulating foreign reserves, to name a few (Bonizzi et al., 2020; Kaltenbrunner and

[15] The terms "peripheral", "emerging", and "developing" countries are all common nomenclatures to refer to countries with a lower level of capitalist development and a relatively weak position in the global hierarchies of currencies and institutions (Lapavitsas and Soydan, 2020). In practice, they refer mostly to middle-income countries. These are examined in relation to "central", "core", or "advanced" economies, a term used in reference to high-income and industrialized nations. In this thesis, we opt for the terms "peripheral" and "central" to refer to these groups; we refrain from using the terms "emerging" and "developing" economies as there seems to be no clear evidence that most countries classified as such have been able to reverse their subordinate position in the global balance of powers over the past decades. This applies to most peripheral countries and especially to those in Latin America. In this latter case, data show that the income and technological gaps of countries in the region in relation to the wealthiest nations have been widening rather than narrowing during the neoliberal period (Bértola and Ocampo, 2012).

Painceira, 2018). The pressures arising out of the subordinated condition play a crucial role in shaping domestic processes of financialization.

Most notably, both trade and the most liquid capital markets are denominated in the currency of central economies, leading to a disproportionately high dependency on foreign capital and currencies. As shown by several authors, processes of peripheral financialization seem heavily driven by attempts to attract the latter (Kaltenbrunner and Painceira, 2018; Karwowski and Stockhammer, 2017; Lapavitsas and Soydan, 2020). Domestic policies geared toward attracting foreign capital and discouraging capital flight would often appear in the form of high domestic interest rates, which lead to high interest rates differentials in relation to central economies (Bonizzi et al., 2020). Especially in Latin America, the chronic need to attract foreign capital is frequently accompanied by the goal of fighting domestic inflation (Becker et al., 2010; Bonizzi, 2013). Thus, peripheral countries would often adopt high interest rates with the dual objective of attracting capital flows and controlling domestic prices. Some of these countries combined high interest rates with inflation-targeting policies to assure that the value of foreign investments would not be eroded by inflation (Epstein and Yeldan, 2008; Frenkel, 2006; Lapavitsas and Soydan, 2020).

Becker et al. (2010) identify two chief forms of financialization, based on asset price inflation and interest income. The first type would be driven by the rising prices of financial assets and appears to be the most recurrent form in central economies. The second type would be fueled by the earnings from interest-bearing capital, and seems to predominate in peripheral regions – particularly in Latin America (see also Bonizzi et al., 2020; Lavinas et al., 2019). This suggests that high interest rates are among the chief drivers of financialization in Latin American countries.[16] Besides promoting accumulation via interest-bearing capital, they lead to high interest rate differentials that, combined with a weaker domestic currency, allow profitable capital flows from the periphery to the center. This sets conditions for the permanent extraction of a significant share of domestically generated surpluses by foreign agents, suggesting that financialization tends to reinforce the dependency bonds upon which it thrives (Becker et al., 2010; Bonizzi et al., 2020; Powell, 2013). Financialization and high interest rates also seem to be associated with the difficulties for peripheral countries to advance in their process of industrialization and achieve higher positions in foreign trade.[17] Karwowski (2020) summarizes the role of high interest rates as a driver of financialization in peripheral countries by observing that "*they open up avenues for financial accumulation to domestic capital potentially at the expense of supporting productive enterprise, while*

[16] This does not mean that all countries in Latin America have undergone significant processes of financialization. This process has spread unevenly in the region, with Brazil and Chile seemingly leading the way (Becker et al., 2010; Lavinas et al., 2019). For comparative assessments differentiating the paths of financialization across "emerging" countries in Latin America, Asia, and Europe, see Bonizzi (2013) and Karwowski and Stockhammer (2017). These studies show that financialization might take a different path in other regions, arising from asset price inflation in the context of low interest rates and fixed exchange rates.

[17] The effects of financialization in holding back long-term productive investments seem an important part of the explanation for the paradoxical fact that Latin American countries underwent a period of deindustrialization in the 2000s even if going through a moment of significant economic growth, led not by manufacture but commodity export (Bortz and Kaltenbrunner, 2018; Bruno and Paulani, 2019; Lavinas et al., 2019; see also Bértola and Ocampo, 2012 and Lavinas and Simões, 2015 for this last point).

feeding the international search for yield of (mostly rich-country) financial investors" (p. 164).

A closer look at the process of financialization in France and Brazil reveals that these countries have followed the general trends associated with financialization in central and peripheral countries discussed throughout this section. As expected, however, it also shows that national circumstances have deeply influenced how these general trends appeared in each case. These dynamics are discussed in further detail in the following sections.

1.2.2 Financialization in France

Fourealt (2008) identifies two main strands of literature investigating the process of financialization in France. The first strand examines transformations at the macroeconomic level, such as the increasing weight of the financial sector in the domestic economy and the massive entrance of foreign capital since the 1970s. This approach encompasses, notably, studies framing such changes as part of a new pattern of capital accumulation; being home to the French regulation school, these usually refer to the onset of a distinctive "mode of regulation" driven by finance (e.g., Aglietta and Rebérioux 2004; Clevenot 2006).[18] Works along these lines demonstrate the role of the State in fostering this process, ascribing these transformations to the deliberate withdrawal of the government in the economy in favor of the private and financial sector (e.g., Coriat 2008). The second strand of literature focuses on transformations at the micro-level, namely the changing behavior of managers and firms in light of increasing pressures coming from the expansion of finance. A prominent body of research on corporate financialization in France emphasizes that traditional structures were not replaced by financialized ones (as seen in other countries), but rather adapted to the expansion of finance while preserving much of their previous forms of organization and control (Dudouet and Grémont, 2009; François and Lemercier, 2017).

Apart from these major axes of research, we can also find a fair amount of research on financialization looking into specific themes. We highlight that which looks at public investment bodies and how they incorporated reasonings and practices typical of financial institutions (Ducastel, 2019). The findings of this strand of research are particularly aligned with our investigation once one of these bodies, the *Caisse des Dépôts et Consignations*, has adopted a new approach toward Social Security agencies and public hospitals since the 1990s. As we will see, this shift has an important role in explaining the latter's greater dependence on financial capital since then (chapter 3).

According to Plihon (2003), France is one of the advanced countries whose economy has undergone one of the most dramatic shifts towards financial markets since the beginning of the process of financial globalization in the 1970s. It was also one of the countries where the government played one of the most active roles in leading this process. Overall, several

[18] The French regulation school seeks to explain how the inherently contradictory capitalist economy can be stabilized over relatively extended periods of time. A key element of regulationist theories is that there are distinctive regimes of accumulation throughout the history of capitalism, each one having its particular mode of regulation – a set of institutions, regularities, and policies that make economic and social reproduction feasible in that particular context (Becker et al., 2010; Bonizzi, 2013; Boyer, 2003).

scholars concur that France has undergone a strong process of financialization with unique characteristics that can be largely attributed to a reorientation of State policies (Coriat, 2008; Lemoine, 2016).

One can only grasp the impacts of the shifts in the French State's approach since the late 1960s and early 1970s, and how they favored the financial sector, by considering its participation in the economy up to that point. The French State had a chief role in both the financing and production of a wide range of goods and services, significantly larger than in neighboring countries, and exerted a major influence over other sectors. To mention a few examples, until the middle of the century, the State (including the central government and other parts of the public administration): (i) controlled the largest share of banks and financial institutions in the country; (ii) was responsible for the intermediation of most of the financing of productive enterprise; (iii) administered domestic interest rates, with an important share offered below market conditions; (iv) exerted direct control over credit and money creation, through the central bank; and (v) was an important shareholder in most of the large industrial and financial companies in the country (Coriat, 2008; Firmin, 2008; Plihon, 2003).

The shift in the State's approach toward private capital was marked by wide-scale privatization programs reaching public banks and companies (Coriat, 2008; Dudouet and Grémont, 2009) and major regulatory shifts in the financial system, including both financial deregulation and the State's let go of total control over monetary and credit emission (Lemoine, 2016). Ducastel (2019) describes these changes as part of a context marked by "*the advent of the 'neo-liberal State' which abandons central planning tools in favor of market instruments in all areas of activity*". The author goes on to say that the liberalization of the financial markets, to which we could add the other reforms previously mentioned, "*[provoked] a movement of financialization that translates itself into the increased dependence of companies, households, but also of the State and its administrations on their creditors*" (p. 35-6).

Coriat (2006) illustrates the deliberate nature of the State's changing approach toward the financial sector by listing some of the main policies upon which it was based:

> **The French State (…) was itself responsible (…) for the genesis of its own disintegration as a key industrial player. Whether in terms of privatization, securitization of the public debt**, the general reform of stock and money markets to increase both their depth and liquidity, or again tax measures designed to shift private savings over to financial markets, these measures represent (…) an **impressive collection of "new regulations"**, distilled, promoted, and instilled continually over the last decades, and **which are at the origin of the ongoing establishment of the new liberalized finance regime**. (p. 79, emphasis added)

These shifts in State policies promoted the expansion of capital markets and the inflation of financial asset prices, which is in line with the overall observations of how financialization expresses itself in wealthy nations (Becker et al., 2010). It is worth mentioning that these changes came about through consistent measures adopted by successive governments from both sides of the political spectrum; although they were mostly initiated by right-wing governments, the left-wing administrations that followed suit

continued and, in many instances, pushed these measures further (Coriat, 2008; Firmin, 2008; Lemoine, 2017).[19]

Changes in State financing were the starting point of this process. This means, more precisely, changes in the way the government financed itself and refinanced its debt. The progressive shift in the orientation of government debt management came about as the State started abandoning administered forms of financing and opted instead to raise funds in the financial markets. In this way, it expanded its sources of financing, but at the expense of becoming dependent on private investors to carry on public policies and subjected to their conditions for servicing its debt.

Lemoine (2016; 2017; 2018) offers the most comprehensive account of how the French State progressively abdicated its control over the national financial system in favor of private finance. As shown by the author, until the 1960s, the government had significant control over its financing sources and actively controlled monetary and credit creation. It did so based on a complex system of non-market financing instruments between the government and financial institutions known as the "Treasury Circuit" (*le Circuit du Trésor*). This public financing arrangement was based on asymmetrical relations between the State and its creditors, with the former holding legal powers to rule on the sources and costs of its own funding. It guaranteed multiple revenue sources for the government that did not require the issuance of marketable bonds, providing funds under conditions and interest rates largely set by the government itself.[20] At the same time, the Central Bank, controlled by the State, had direct control over money creation, fixing the volume of credit each establishment could offer and regulating interest rates (see also Plihon, 2003).

The late 1960s marked the beginning of the "financialization of the public debt" (section 1.3.3), with the progressive abandonment of administered financing mechanisms in detriment to market-based financing.[21] From this moment on, the State started issuing securities to borrow from financial markets. This new financing modality worked by offering bonds in auctions, at market interest rates. These government securities were standardized and exchangeable, which could become financial assets traded by financial investors in secondary markets.

The reasons leading the State to turn to financial markets seem to have been both ideological and practical. Lemoine (2017) draws attention to the emerging ideological context of the period, which focused on countering inflation and deemed the existing government financing modalities as highly inflationary. The emerging tensions surrounding

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[19] During an important part of the initial period of reforms, France was governed by Georges Pompidou (1969-1974) and Valéry Giscard (1974-1981), right-wing presidents. They were followed by François Mitterrand (1981-1995), who led a nearly fifteen-year term of the socialist party.

[20] Among the various revenue sources that composed the "Treasury Circuit", we can mention the deposits of public banks, public companies, and other financial institutions linked to the State in the French Treasury, the issuance of non-negotiable debt obligations, and the mandatory subscriptions to Treasury obligations imposed on banks. For a detailed description of this "circuit", see Lemoine (2015).

[21] This process through which the State issues securities in financial markets is most often referred to as shifts in "public debt management" or "sovereign debt management". Other expressions used in the literature to denote this process include the "marketization of the public debt" and the "securitization of the public debt". We will address them in further detail in section 1.3.3.

the issue of inflation would have pressured the government to search for alternatives. At this time, the appeal to international savings and foreign investors was advertised as the only "healthy" and non-inflationary means to finance the public sector (see also Lemoine and Ravelli, 2017). Plihon (2003) adds that the increase in public debt levels around the time made it impossible for the Treasury to continue relying on domestic investors, leading to the use of market instruments to incorporate foreign capital. The government implemented far-reaching policies to modernize and liberalize domestic financial markets in this period, serving both to allow foreign investors to buy French government bonds and meet their demands. Putting these elements together, there is reason to believe that the government's decision to resort to the markets in a systematic fashion resulted from a dual political aim to both curb inflation and develop liquid capital markets (Lemoine, 2017).

The changes in the government's approach to public financing would mark the beginning of the financialization of the State to the extent that, from this moment on, "*the State had to live as a borrower, not as an economic sovereign. (...) It became a debt issuer among others and began competing with other States to finance itself in the markets*" (Lemoine, 2017, pp. 242, 253). This had implications for policy-making processes and public expenditures. As the State became exposed to the judgment of globalized private capital markets to obtain credit, it was now subject to their conditions to keep running the public machine. This involved, in particular, expectations to pursue a balanced budget and maintain a sustainable level of indebtedness (Lemoine, *op. cit.*).

The State's turn to the markets and the financialization of the public debt played a central role in the financialization of the French economy in a number of ways. Firmin (2008) notes that the State emerged as a gigantic source of demand for credit, now covered by private investors. Moreover, the dismantling of existing arrangements for public financing and credit creation, along with the waves of denationalization, meant that companies could no longer count on the government to control credit and cover their capital requirements. According to Dudouet and Grémont (2009), this promoted the expansion of private financial markets as companies turned to private financing instruments to raise funds, namely in the form of credit obtained from private banks and securities issued in financial markets.

Aside from the government, French businesses and families also formed new and deeper ties with the private financial sector in this period. For Firmin (2008), the financialization of financial and non-financial firms could be observed in the rise of the profit share in the country, the increase in the external financing of companies through securities issuance, the intensification of shareholder value orientation as a consequence of this new financing modality, a larger share of profits distributed as dividends, and a downward trend in the rate of accumulation (see also Karwowski et al., 2020; Plihon, 2003; Stockhammer, 2004).

Compared to the existing literature for the State and firms, there seem to be fewer published works investigating how households in France have been incorporated into the process of financialization (Lazarus and Lacan, 2020). We know that the regulatory changes carried out by the government throughout the second half of the 20th century also reached households, mainly by encouraging them to hold financial wealth. The government created

a vast range of regulatory and tax incentives attempting to promote the reorientation of household savings from the acquisition of housing and capital goods to investments in financial assets. These included government securities, life insurance plans, voluntary pension savings, and allocations in investment funds, to name a few (Coriat, 2008; Firmin, 2008). While these incentives increased the volume of households' financial investments, the latter remained concentrated in the hands of a relatively small and wealthy segment of the population. Several studies examine data for household wealth in France and find indisputable evidence that the upper classes hold the vast majority of the financial assets in the household sector until today. Accordingly, they also receive the largest share of financial income addressed to households (Firmin 2008; Lemoine 2019; Plihon 2003).

Apart from investments, there are also the bonds between households and the financial sector formed through debt. Evidence suggests that household indebtedness has increased significantly in France over the past decades. Data from the French Central Bank point to a rise in household debt-to-income ratio from 52% in 2000 to 94% in 2018. Moreover, the share of household debt due to consumer credit is now higher than that from mortgage loans (Banque de France, 2019a; Eurostat, 2021; La finance pour tous, 2019). Notwithstanding this rise, some authors remark that household debt levels in France remain inferior to those of some neighboring countries (Karwowski et al., 2020; Lazarus, 2017).

To our best knowledge, it remains an open question whether the process of financialization in France has gone through different phases over time. Firmin (2008) acknowledges the difficulties in establishing a periodization of the process of financialization in France. The most popular systematization of different stages of this process, carried by François and Lemercier (2017; 2016), considers only the micro-level of firms.[22] Despite its restricted scope, this research uncovered an interesting particularity of the French process of financialization; the fact that existing corporate structures and their bonds with State actors were largely preserved during this process. More specifically, traditional managers from listed firms, the so-called *grands patrons* ("big bosses"), did not lose their place to financial managers but rather incorporated the latter's practices and behaviors to become financial elites. The authors show that the long-standing personal and professional connections between the corporate sector and the public administration were largely preserved during this process, resulting in extremely permeable boundaries between the public, corporate, and financial spheres (see also Dudouet and Grémont, 2009).

1.2.3 Financialization in Brazil

Brazil did not escape the logic of "financial dominance" that governs contemporary capitalism, a phenomenon observed by Braga (1985) since his first works on the subject back in the 1980s.

[22] The authors distinguish two phases of corporate financialization in France: the first phase, around the 1970s, was marked by the growth of financial firms in size and influence; in the second phase, around the turn of the century, what stand out were changes inside financial and nonfinancial firms, including in their shapes and objectives (the greater orientation toward shareholder value being a case in point).

Looking at the external events, Paulani (2010) emphasizes the country's role as a major source of demand for international credit in the 1970s, contributing to expanding financial accumulation in the center in this period as well as during the subsequent foreign debt crises. The author also argues that Brazil's involvement in the expansion of global financial markets continued in the 1990s as the country emerged as an international platform for financial valorization. This was a result of far-reaching reforms that turned it into an emerging economy opened to foreign capital and with some of the highest interest rates in the world, creating opportunities for extremely high gains in strong currencies (see also Freitas and Prates, 2001; Campello and Fontana, 2020). With an eye toward internal events, other authors put greater emphasis on how changes in domestic policies since the 1970s led national companies and banks to prioritize the accumulation of financial assets instead of productive investments (Braga, 1985; Bruno et al., 2011; Lavinas et al., 2019). Due to its importance in understanding the financialization of public policies in the country, this latter perspective will be the focus of our discussion throughout this section.

The literature on financialization in Brazil has also focused on some core topics. The most prominent strand of research is arguably the one looking at macroeconomic policies and indicators, which addresses how macroeconomic policies contribute to financial accumulation and how the latter, in turn, has an effect on macroeconomic aggregates. Within this body of works, we find authors arguing that these structural changes configure a distinctive "macroeconomic regime" or "accumulation regime" in the country, driven by finance (Araújo et al., 2012; Bresser-Pereira et al., 2020; Bruno et al., 2011; Lavinas et al., 2020, 2019; Paulani, 2010). In addition to macroeconomics, there is also systematic research at the micro-level of firms. This includes studies that investigate to what extent financial imperatives alter the behavior of non-financial companies and changes their investment patterns (Attílio and Cavalcante, 2019; Branco, 2010; Feijó et al., 2016; Fellows, 2019). Lastly, the impacts of financialization on areas of social provision, such as health care, education, and pensions, have also been a subject of sustained research activity in the country over the past decade (e.g., Bahia et al., 2016; Bressan, 2020; Cordilha and Lavinas, 2018; Lavinas, 2015a, 2017; Lavinas and Gentil, 2018; Leher and Accioly, 2016; Martins et al., 2021; Sestelo, 2017a).

Like France, Brazil went through an early process of financialization heavily led by the State (Bruno et al., 2011; Lavinas et al., 2019). While the role of the State leading this process can also be traced back to a changing approach for government financing in the 1960s, this appears to have been important not so much for promoting private capital markets but due to its role in protecting financial investments in times of high inflation. Overall, there seems to be a shared understanding that the fight against inflation is at the heart of the financialization process in Brazil. However, the dynamics of domestic inflation, and the State policies to counter it, varied greatly over the decades, which means that the process of financialization also underwent different phases.

There is a cohesive body of literature offering a periodization of financialization in Brazil, explaining its origins and different phases up to today (Araújo et al., 2012; Bruno et al., 2011; Lavinas et al., 2020, 2019). These authors identify three main phases of financial accumulation in the country since the 1970s. The decisive factor triggering the transition

from one phase to the other has been a shift in State policies. Despite the differences that separate the several governments in office over this period, both right- and left-wing presidencies have played an active role in creating, maintaining, and expanding the policy framework that allowed financialization to advance (see also Bruno and Paulani, 2019; Gentil and Hermann, 2017; Lavinas, 2017).[23]

To understand the onset of the first stage of financialization, it is necessary to explain the changes in State financing and debt management that laid the basis for it to happen. Such changes came in the 1960s, when the Brazilian government started on its path of financialization of the public debt (section 1.3.3) by issuing standardized and negotiable public debt bonds in auctions. A defining aspect of the Brazilian experience has been the government's concern, since the very beginning, with protecting investors against the depreciation of their investments in public bonds due to inflation. It is telling that the first government negotiable bonds, created in 1964, were called "Readjustable National Treasury Bonds" (*Obrigações Reajustáveis do Tesouro Nacional*) for having their value periodically adjusted according to inflation. Over the following decades, the public debt market expanded significantly with the creation of several other types of public securities, including fixed-rate and inflation-linked bonds (Araújo, 2002; Pedras, 2009).

This shifting approach to State financing and debt management set the foundations for the takeoff of the first stage of financialization from the 1980s to 1994 based on what were called "inflationary gains". Bruno et al. (2011) offer the first detailed account of the onset of financialization in the country during this period. In the context of a long-lasting inflationary crisis, indexed public debt bonds served to create an alternative currency that allowed for significant financial gains.[24] The "dual currency" system, unique to the Brazilian experience, was based on the coexistence of two currencies: the official currency, issued by the State, and the alternative, "financial currency", issued and managed endogenously by the banking sector. While the former had its value continuously eroded by price increases, the latter was backed by public debt bonds indexed to inflation (Araújo et al., 2012; Bruno et al., 2011). This system became both the primary policy strategy to cope with inflation and the main channel for financial accumulation.

The "pegged currency" served to create very short-term contracts with positive real interest rates and very low risk, allowing financial institutions and privileged investors from the upper middle classes to reap financial gains thanks to monetary correction mechanisms (Lavinas et al., 2019; Oliveira, 2010). The implementation of this system, albeit limited in scope and scale, is considered the trigger of financialization in Brazil. It set the conditions for a period of intense rentier accumulation by financial institutions and high-profile investors, as well as a significant expansion of these institutions based on operations with

[23] We can highlight a number of important political turnarounds in Brazil during the period under discussion: the rise of the military dictatorship in 1964, the transition to a democratic regime during the late 1980s, the election of a right-wing president in 1995 (Fernando Henrique Cardoso), his replacement for left-wing leaders from 2003 to mid-2016 (Luiz Inácio "Lula" da Silva and Dilma Rousseff), and a process of impeachment in 2016 that paved the way for right-wing, highly conservative governments over the following years (Michel Temer and Jair Bolsonaro).

[24] Inflation rates in Brazil reached 431% p.a. on average between 1980-9 and 1,321% p.a. in 1990-4, measured by the National Consumer Price Index (IBGE).

these highly liquid and profitable assets (see also Araújo et al., 2012; Lavinas et al., 2020, 2019).

The previous mechanisms of financial accumulation from indexed public debt instruments were shattered in 1995 due to the sharp fall in inflation rates as a result of far-reaching monetary reforms to keep it under control.[25] However, rather than disappearing, new structures of financial accumulation emerged in line with the newly established policy framework. The second phase of financialization, from the mid-1990s to the mid-2010s, was based on interest income. This came due to strict inflation targets imposed by the government since the mid-1990s and the implementation of an inflation targeting regime in 1999, which justified permanently high real interest rates to reach them (Bruno et al., 2011). We refer, in particular, to the basic interest rate set by the Central Bank (the "Selic rate"), which influences the remaining interest rates in the economy.[26] Several studies demonstrate that both the basic and average interest rates in Brazil have been among the highest in the world since the mid-1990s (Bresser-Pereira et al., 2020; Bruno and Paulani, 2019; Lavinas, 2017).

In the context of persistently high real interest rates, the front for financial accumulation shifted from inflationary gains to interest income. The chief sources of financial profits in this period came from high-yielding public debt bonds and investments tied to the latter. Furthermore, the rise in general interest rates fueled gains from other sources such as bank loans, namely due to the expansion of credit. In contrast to the former, "eliticized" phase of financialization, the process of financialization reached an entirely new scale and scope from the 2000s onward due to the massive expansion of credit to households, characterizing a period of "mass-based financialization" in the country (Lavinas et al., 2019). This stage was heavily driven by the expansion of consumer credit and financial services, including those related to sectors within the sphere of social policy (e.g., private pensions, health insurance, student loans). Another salient feature was the use of social policy benefits as collateral for a significant part of such instruments (Lavinas, 2018b, 2017). This context allowed for extraordinary financial accumulation from sovereign bonds, loans, and derivative assets, remunerated at interest rates far higher than their foreign counterparts. Banks, investment firms, large national and foreign companies, and rentiers were among those that profited the most in this period (Araújo et al., 2012; Bruno et al., 2011; Lavinas et al., *op. cit.*).

As a result of a sharp economic slowdown starting in 2014 (with negative growth rates of the GDP in 2015-16 and sluggish recovery afterward), the government started reducing the basic interest rate. This seemed to have weakened, once again, the existing structures of financial accumulation. The late 2010s seem to mark a third phase of financialization, based on capital gains. While interest rates followed a downward path in the second half of the decade, the volume and value of stock market operations soared to

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[25] This was mainly due to a new stabilization program, the Real Plan, launched in 1993-4. As will be explained in chapter 4, this stabilization plan managed to control inflation not only because high interest rates constrained demand, but mainly due to the fact that they countered currency devaluation. This was allowed by attracting large volumes of foreign capital, remunerated at high interest rate differentials.

[26] The Selic fulfills multiple roles in the Brazilian economy. Among them, it serves as the interbank lending rate, as the reference for the remuneration of a significant part of public debt bonds, and as a parameter for other interest rates.

unprecedented levels.[27] This trend became apparent in 2016 and accelerated in the following years, with these operations reaching historical highs in 2019. Corporate credit was also on the rise. The opposed trajectories between interest rates and stock market capitalization led Lavinas et al. (2020) to formulate and test the hypothesis of a transition to a new financialization pattern driven by the investments in shares and corporate credit. The authors find robust evidence of a change in the locus of financial accumulation from interest income toward both capital gains from shares and the extension of credit to companies. Another interesting finding is that the increase in market capitalization and corporate debt did not encourage innovation and productive investments; on the contrary, companies turned to debt to buy back their shares for securing future appreciation and speculate on other companies' shares. Despite the convincing results, the recent nature of this process calls for continued research to confirm this as a new phase of financialization.

The body of research presented above demonstrates that the State directly sponsored the process of rentier accumulation in Brazil by setting high interest rates and creating investment opportunities to reap interest income on a permanent basis. These results are in line with the idea that financialization in peripheral countries, especially Latin American ones, is based on the accumulation of interest-bearing capital and unfolds in a context of fighting inflation (Becker et al., 2010; Bonizzi, 2013).

Beyond new relations between the State and finance, the process of financialization also entailed changes in how businesses and households interacted with the financial sector. Several studies demonstrate that, in the context of underdeveloped financial markets and attractive interest-bearing investments, non-financial Brazilian companies shifted behaviors from their typical activities toward rent accumulation. These studies find positive correlations between high interest rates, overvalued exchange rates, and low rates of fixed capital formation (Bruno et al., 2011; Feijó et al., 2016; Lavinas et al., 2020, 2019). Micro-level analyses further support this view by showing that the quest for financial income was a determinant driver of investment decisions in Brazilian non-financial companies, leading them to increase the volume of funds invested in interest-bearing assets and remitted to the financial sector (Fellows, 2019; Rabinovich and Artica, 2020). Unsurprisingly, the country followed a path of precocious and progressive deindustrialization since the 1990s, which can be at least partially attributed to the process of financialization (Araújo et al., 2012; Bruno and Paulani, 2019; Lavinas et al., 2019).

To end, the incorporation of Brazilian households is one of the most remarkable aspects of its financialization process. Since the 1990s, and particularly after the 2000s, the scope of individuals connected to the financial system has grown dramatically, reaching medium- and low-income households (Lavinas, 2015a, 2017; Lavinas and Gentil, 2018). Rich and poor households, however, participated and benefited differently from the expanded access to the financial system. Given the extreme concentration of the stock of real and

[27] As shown by Freitas and Prates (2001) and Lavinas et al. (2020), Brazilian governments made continuous efforts to promote the expansion of the country's capital markets since the 1990s, which nonetheless was kept in check during most of the financialization period. The level of the Brazilian basic interest rate was the main reason for poorly developed capital markets, making government bonds far more attractive than riskier investments.

financial wealth, the possibility of profiting from financial investments remained limited to the highest income brackets. The richest segments of the population continued owning the largest share of financial assets held by families and receiving most of the financial income provided by the latter. It is worth noting that the much-heralded decrease in social inequality in Brazil during the 2000s is skewed toward methodologies based on labor income; when accounting for financial rents as well, the results point to an increase in income concentration at the top of the distribution, much driven by financial gains (Medeiros and Castro, 2018; Morgan, 2017, 2015).

Different from financial investments, debt is spread across the entire social pyramid and has advanced significantly toward the middle- and low-income classes. Interestingly, the financialization of households in Brazil followed a dynamic that escaped the usual observations of financialization studies: household indebtedness increased simultaneously with rising wages, lower unemployment rates, and declining labor income inequality (Bruno and Paulani, 2019; Lavinas et al., 2019).[28] Lavinas (2017) explains this paradox by noting that the social reforms in the neoliberal period prioritized monetary benefits over universal service provision, making individuals resort to credit and financial instruments to access essential and non-essential goods and services. The credit boom was heavily encouraged by the government through programs to promote "financial inclusion" and regulatory changes to facilitate individuals to take out loans. Civil servants, pensioners, and the groups at the bottom half of the distribution became a fast-growing market niche for loans and insurance instruments, typically of low value and limited coverage (see also Bruno and Caffe, 2014; Sciré, 2011; Lavinas et al., 2019).

As previously noted, the expanded access to credit in the country was so important that it marked a new phase of the process of financialization at the turn of the century. Household debt-to-income ratio more than doubled in less than fifteen years, from approximately 20% in 2005 to over 45% in 2018 (Banco Central, 2020). Low-income households were the most adversely affected by the rising levels of household indebtedness; the volume of debts relative to average income is now significantly higher for them than for middle- and high-income households. The same goes for the share of household income dedicated to covering the costs of debts (Banco Central, 2019; Lavinas, 2017).

Taken together, the elements presented so far suggest that the process of financialization in the Brazilian economy is in agreement with what was previously suggested by the literature on peripheral financialization. It also shares important commonalities with trends documented in the literature of financialization at large and observed in the French case. Among them, Bruno et al. (2011) and Lavinas et al. (2019) highlight the unprecedented financial expansion and banking concentration since the 1970s, a rise in the personal and functional concentration of income and wealth, the decline in productive investment rates, the mounting levels of household indebtedness, and the affirmation of rentier behaviors in non-financial firms and high-income households. Another

[28] Becker et al. (2010) use the concept of "popular" financialization to denote the incorporation of masses into this process. They do not consider this to be the case in Brazil due to social reforms in the 2000s, which would have the effects of counteracting financialization. However, as we discuss, studies provide evidence that social reforms and financial inclusion went hand in hand in the more recent period.

trait identified by these authors, and consistent with the previous discussion, is the apparent loss of State autonomy in the formulation of public policies, with an increase in the political power of the rentier classes and capital owners over the State apparatus.

1.3 Financialization and social provision

The inroads of modern finance into relatively unexplored territories have been fundamental in allowing it to reach its current scale and influence in other domains of social and political life (Bryan and Rafferty, 2014; Fine, 2014, 2009; Lavinas, 2020, 2018b; Leyshon and Thrift, 2007; Storm, 2018; Thomson and Dutta, 2015). When referring to areas of social provision, or social policy, we refer to those policy fields traditionally associated with social rights and provisions such as health care, pensions, housing, education, and income support (Karwowski, 2019; Lavinas, 2018a). The involvement of financial players in such activities, previously limited and regulated, has expanded dramatically over the past decades. The expansion into areas of social provision is one of the distinctive traits of the process of financialization of the world economy. This process has become visible as market mechanisms have been encouraged to enter these previously "sacred" areas (Stenfors, 2016) and change their inner workings. Due to its strategic importance to our investigation, the last part of this chapter engages in the discussion of how financialization has been reframing State action in areas of social provision. To make sense of this phenomenon, we propose an original systematization of the existing research on the topic, differentiating the ways in which financialization reshapes social provision along its key dimensions: access, financing, and provision.

1.3.1 The inroads of finance in areas of social provision

Before discussing how financial actors are participating in areas of social provision, it is important to interrogate the reasons leading them to do so. Leyshon and Thrift (2007) offer an insightful answer to this question. The authors suggest that financial actors would be interested in expanding their participation in those areas due to their desire and need to find new spaces for financial profit extraction, which is necessary for the continuous accumulation of financial capital. This process would materialize via the incorporation of regular income flows from other sectors and their manipulation to obtain liquidity and solvency for financial transactions. In their own words, "*financial capitalism is dependent on the constant searching out, or the construction of, new asset streams (...) previously considered trivial or off-limits and their incorporation into the financial system*" (pp. 98, 101). These income streams could serve as collateral for lending, investing, and trading, allowing agents to expand financial activities and the capacity to reap financial returns.

In this process of prospecting for new sources of revenues, anything that might provide a stable stream of income for capitalization and speculation can be brought into play (Leyshon and Thrift, *op. cit.*). This forcefully extends to areas critical to social reproduction, which rely on relatively secure revenues streams. These include, for example, the disbursements made by governments, households, and firms to finance the provision and

access to goods and services in health, housing, and education, to name a few. Changes in social policy can enable and foster the creation of financial assets and collateral based on these activities. In this way, part of cash flows originally channeled to areas considered essential to human subsistence and development is diverted to the financial sector. Acknowledging this phenomenon can be considered one of the chief contributions of the literature on the financialization of social policy discussed in this section.[29]

Moving on to the question of *how* finance will enter those sectors, a review of the literature on financialization across these areas provides evidence of the transformative effects of financialization on both ends of social provision – on the one hand, the forms through which the public sector finances and provides goods and services, and, on the other, the ways in which individuals access them. In each case, there seems to be an increased dependence on financial instruments and institutions. This is why we propose to make sense of such trends by organizing the existing research along these two dimensions – from the perspective of the entities providing these services and the individuals accessing them. Following a chronological order, we begin by reviewing works that look at individuals and households, examining how their conditions of access to goods and services are changing in the period of financialization. They often characterize such changes as part of the process of "financialization of social policy". Next, we present the discussion offered by studies demonstrating how governments and public sector institutions are redesigning the ways to finance and deliver social goods and services in the context of financialization. This has been explored within the research on the "financialization of the State".

1.3.2 The financialization of social policy

Works on the "financialization of social policy" (Fine, 2014, 2009; Lavinas, 2018b, 2017, 2015b) were the first to engage in continued and systematic research on the impacts of financialization in areas of social provision.[30] We argue that their discussion offers an account of the transformations in social policy from the perspective of citizens, addressing how their conditions of access to essential goods and services change in financialized capitalism and critically examining the role of the State in driving this shift.

From a collective reading, the main phenomenon that seems to characterize the financialization of social policy is the increasing weight of financial institutions and products as means to access consumer goods, essential services, and investment in life opportunities, replacing what was previously fulfilled (or expected to be fulfilled) by public provision. This depends on a transformation in the State's approach toward the latter. In particular, it thrives, on the deterioration of comprehensive public provision, which would lead individuals to turn to the markets to access basic goods and services intermediated by financial instruments. Loans and insurance are two examples of financial instruments that can cover needs in essential areas of human life where the State is stepping back.

[29] Our case studies in chapters 3 and 4 will illustrate how this occurs in the case of PHS, an area where this discussion is still in its infancy.

[30] For further empirical evidence, see the several studies carried out under the Financialization Economy Society and Sustainable Development (FESSUD) project (www.soas.ac.uk/fessud/).

Fine (2009) refrains from providing a specific definition of the financialization of social policy, underscoring its variegated nature across countries and sectors. The author argues, however, that any transformation in social policy that creates a stream of revenue consolidated into assets traded in financial markets could be potentially interpreted as such:

> Neoliberalism (…) [is] heavily underpinned by an extraordinary expansion and promotion of financial activity. This goes far beyond the proliferation of the financial markets themselves (…) to an ever-expanding range of activities associated with both economic and social reproduction (…)
>
> (...) the relationship between financialization and social policy is neither uniform nor always or even primarily direct. It is more so **where the private has displaced the public sector with corresponding incorporation of financial markets into the process of provision**, as most notable with housing and pensions. But **any form of privatization has the potential to induce financialization since it creates a stream of revenue that can be consolidated into assets that can become part of a derivative that is speculatively traded**. (p. 5, emphasis added).

Lavinas (2017) conceptualizes the financialization of social policy as the "*uncoupling of social policy from its previous modus operandi, now rewarded by institutional arrangements based on the prerogatives of the financialization process*" (p. 9). The distinguishing feature of the present historical moment, in her view, lies in the role that the financial sector takes on as a gateway to access social goods and services previously considered being under the State's mandate. This would be most glaringly seen in the expansion of financial instruments in areas whose access has been traditionally associated with social rights, where public provision is expected to be universal and irrespective of the citizen's ability to pay. Consumer credit, payday loans, microcredit, student loans, private pension plans, and health insurance are cases in point. The growing availability of such products over the past decades indicates consumers are appealing to the markets to ensure access and protection against risks in sectors like health, old age, and education, as well as to complement income (Lavinas, 2018b, 2018a, 2017). This dramatic expansion of credit and insurance products come with a new scope, now reaching middle- and low-income classes, and it is assigned new purposes, including that of offsetting the deterioration of public provision.

Fine (2014) interprets these transformations as evidence of a process of "*turning provision into a financial asset, however near or distant*" (p. 33). According to Lavinas (2018b), they provide compelling evidence of how "*welfare is recommodified and financialized*" (p. 178). The financialization of social policy can be regarded as a two-sided process in which "*more and more households will rely on financial markets for the provision of social goods, while public provision shrinks and deteriorates*" (Lavinas, 2017, p. 83). In other words, free, universal provision of in-kind goods and services by the State has to retreat for private, financialized alternatives to advance.

These studies contribute to dispelling the misconceived idea that the impacts of financialization on social policy are restricted to budget cuts and pressures in favor of the privatization of public services. Instead, they show that these are only on the "tip of the

iceberg" (Lavinas et al., 2019) of a far deeper transformation in social policies in the period of neoliberalism and financialization. The financialization of social policy does not mean that social policies necessarily diminish in importance, but that their nature and scope change. The paradigm of social policy forged in the aftermath of the Second World War was based on a specific approach to State provision (Fine 2014, Lavinas, 2018b). When it comes to in-kind provision, it promoted universal and publicly provided (or highly subsidized and regulated) services in all levels of complexity. In the case of monetary transfers, it prioritized comprehensive schemes of pension and assistance benefits. Such an approach oriented much of the formulation of social policies in the 20th century (up until the neoliberal era), even if heterogeneously and with pitfalls.

In contrast, in the period of neoliberal, financialized capitalism, the blueprint of social policy is characterized by an increasing focus on basic service provision and cash benefits. One can observe the widespread presence of this new approach to social policy as governments from both central and peripheral countries have become increasingly inclined to prioritize social spending in the form of low-value monetary transfers, such as minimum pensions and conditional cash transfers, and public service provision focused on the most basic services and vulnerable individuals – for instance, primary health care and primary education.[31] This logic of social provision based on principles of targeting, residualism, and selectivity opens space for the expansion of finance in areas of social policy.

On the one hand, the current approach to social policy supports the expansion of finance to the extent that areas of social provision constitute market niches in which financial instruments can only gain participation if public, universal options are removed or minimized (Bayliss et al., 2016a; Lavinas, 2020).[32] On the other, cash transfers can be used for citizens to acquire those services in the markets, with the help of financial products, as well as to withdraw risks for the financial institutions providing the latter. The transformation of monetary benefits into collateral for credit and insurance, allowing previously excluded groups of the population to engage in financial practices, is the ultimate example of this development. Lavinas (2018b) refers to the "collateralization of social policy" in instances where regular State payments (pensions, assistance benefits, and others) serve as collateral to access credit. She shows that this phenomenon was key in boosting the process of financial inclusion in some countries, enabling even welfare recipients to become potential borrowers.

The remaining services provided by the State tend to focus on riskier and less profitable activities, as well as on the more vulnerable population groups, also contributing to the expansion of financial activities. While public provision covers areas in which profit margins are unattractive and for the "hard to serve", finance can act only where and when there is

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[31] This "residual" approach to social policy has been expanding with the support of multilateral institutions and international organizations. A telling example is the "Universal Health Coverage" proposal from the World Health Organization. Despite its name, this proposals is based on concepts of universality much more restricted than those of the post-war period (see chapter 2).

[32] Some authors note that private finance and social policy serve similar purposes, such as providing individuals with means to prevent and manage risks, smoothing out consumption throughout the life cycle, and increasing the level of disposable income. This is the case even though they work under different principles and leading, therefore, to different outcomes (Lo Vuolo, 2016; Sarlat, 2012). The acknowledgement of such (to some extent) interchangeable roles further supports the idea that the restriction of public provision opens space for financial activity.

potential for profit extraction (Bayliss et al., 2016b; Fine and Bayliss, 2016; Lavinas and Gentil, 2018). Summing up, instead of promoting comprehensive systems of public provision, this neoliberal approach to social policy serves to increase the demand for financial assets, promote “financial inclusion”, and underwrite risks for the financial sector, feeding the latter’s continued expansion.

This literature is closely related to the body of studies on household indebtedness (e.g., Fraser, 2016; González, 2020; Mader, 2015; Mertens, 2017; Montgomerie, 2020, 2006; Roberts, 2016; Soederberg, 2014), which associates the process of financialization with the significant rise in household debt over the last decades. Given the deterioration of wages, working conditions, and universal public provision associated with this process, credit would allow households to cover increasing financing gaps to access durable goods, meet daily needs, and cope with contingencies (Lavinas, 2018b). As explained by Roberts (2016), *“debt has emerged as a key means through which households have sought to meet the costs of social reproduction being offloaded by the State (through welfare retrenchment) and capital (through low wages and precarious working conditions)”* (p. 145). Recent studies have noted that household debt can grow even in the context of rising salaries and average income (ECLAC 2018; González, 2020; Lavinas et al., 2019). This suggests that the financial system is playing a role in domestic life that goes beyond that of compensating for falling wages.

The most significant impact associated with such a transformation in social policy is its effects in deepening social inequalities. Greater inequality comes as a result of the progressive dismantling of policies based on universalism and comprehensive provision, which are essential for promoting basic standards and equal opportunities among individuals. In the context of the financialization of social policies, the quantity and quality of access to services become differentiated according to income levels, as these determine how each individual will be able to engage with the financial system. The conditions of access to financial assets, insurance, and debt depend on the capacity to pay and provide collateral (Fine, 2014; Lavinas, 2018a, 2018b). In this way, these transformations undermine one of the chief goals of State intervention in areas of social provision, which is promoting social equity.

Authors often mention the heterogeneous impacts of household debt across income groups to illustrate the social disparities generated by present forms of financial inclusion. Lapavitsas (2013) proposes the term “financial expropriation” to describe the transfer of income from households directly to the profits of the financial institutions that have played this mediating role for the private provision of goods and services. As reminded by Mertens (2017), the rich and the poor are unevenly integrated into the financial system, making their risks also unevenly distributed. The costs of debt are a particularly important and unequal risk. The literature on household financialization presented in this section underscores that much of the recent credit growth originated from lower-income households, who usually cope with a larger debt burden in relation to their income, face worse borrowing conditions, and are the most exposed to economic shocks (see ECLAC, 2018 and IMF, 2017 for empirical data).

The factors discussed in this section allow us to pinpoint a first effect of austerity on social policy: legitimizing and promoting the downsizing of public, comprehensive provision. In the neoliberal period, there is a rhetoric that public provision systems are overspending (Bayliss and Fine, 2020; Fine and Bayliss, 2016) and that the State must cut public expenditures with the latter to balance the public budget, a requirement of creditors and the international community (Lemoine, 2016; Streeck, 2014). This justifies reducing the scale and scope of universal, publicly provided services, which "*run counter to the neoliberal principles of a slim State*" (Lavinas, 2018b, p. 509). In their place arise cheaper options of social policy, the targeted and residual services and transfers that create opportunities for private finance. Yet, austerity and finance also work together in another dimension, reshaping how the public sector will finance the service provision still under its responsibility. This will be the object of discussion in the following section.

1.3.3 The financialization of the State

Notwithstanding their value as reference works, studies on the financialization of social policy focus on examining developments from the perspective of citizens, unveiling how "*modern finance has upended the logic of access to rights*" (Lavinas, 2020, p. 312). They underscore how the State plays a crucial role in orchestrating these changes by reshaping its approach to social policy in ways that feed the expansion of financial instruments, institutions, and markets. Yet, social provision involves not only the population and the ways in which they access essential goods and services; it also involves public entities and how they finance and provide the latter. While it is true that part of public services is being narrowed or scaled down, another part continues to be under the State's responsibility, including in the case of services provided free or highly subsidized at the point of delivery. As a result, there is the need to investigate the mechanisms through which financialization reshapes those parts of service provision that continue to be public, and especially those that continue to be universal. This requires inquiring whether and how governments and public bodies at large may also be turning to financial instruments, institutions, and markets to fund and provide the goods and services that remain within their purview.

A second line of research within the financialization literature can help further understand how public actors might be resorting to financial capital to ensure the continuation of social provision. In this strand, we include works concerned with what they refer to as the "financialization of the State" (e.g., Fastenrath et al., 2017; Karwowski, 2019; Lagna, 2016; Pagliari and Young, 2020; Schwan et al., 2020; Wang, 2020, 2015) and the "financialization of public policies" (Chiapello, 2020, 2019, 2017).[33] The notion of "State" appears here in a broad meaning, encompassing the ensemble of entities and policies that make up the public administration. These scholars use the concept of financialization to examine the changing relationships between the financial sector and central governments, local governments, public service departments, state-owned institutions, and Social Security

[33] For the sake of simplicity, we will adress these body of works collectively as the literature on the "financialization of the State", and use it interchangeably with the expression "financialization of the public sector".

agencies, to name a few.[34] This reflects an interpretation of the State not as a cohesive entity, but as a varied array of apparatuses and branches where different interests are under permanent dispute. Within this literature, there is a widespread understanding that these areas can carry contradictory policies between them, and that the pendulum tends to swing in favor of policies that favor the dominant groups.[35] Although this research does not focus exclusively on issues related to social policy, it provides insights into developments in the latter. It does so by illustrating how financialization reshapes the ways in which public sector entities operate and carry public policies, which naturally extends to the entities responsible for social provision and the policies related to it.

Karwowski (2019) conceptualizes the financialization of the State as "*the changed relationship between the State (...) and financial markets and practices*" or, alternatively, as "*the increasing influence of financial logics, instruments, markets, and accumulation strategies in State activities*" (pp. 1001-2). Similarly, for Wang (2020), the scholarship on State financialization interrogates "*how State ideas, State organizations, and State-making processes dovetail with the expansive mechanisms of finance*" (p. 192). Pagliari and Young (2020) argue that such a revolution in the relationship between the State and finance can be observed in practice through various instances where public actors are relying on financial markets, indicators, and instruments. Wang (2020) emphasizes the relevance of such transformations insofar as they represent "*a rising paradigm of governance and a new form of statecraft*" (p. 188) in which States strategically turn to finance for several purposes such as refinancing the public debt, providing public goods, and stimulating growth. This changing form of governance entails a novel approach to public policies. Taking the latter as a starting point, Chiapello (2017) defines the financialization of public policies as "*the penetration of financialized logics and forms of evaluation in the formulation and implementation of policies, even when these do not involve the financial sector*" (p. 27). Said otherwise, the distinguishing feature of the financialization period would be that these processes entail changes in how States act, including when it comes to areas unrelated to the financial sector.

As in the case of the literature reviewed in the previous section, which shows that financialization does not simply "shrink" social policies, this body of works also contributes to dispelling some misguided beliefs associated with this process. One of the chief contributions of this strand of research is to challenge the idea that the State contributes to the financialization process mostly by facilitating the advancement of financial activities in

[34] In this thesis, we refer to the "State" in the broad sense applied by this literature, using it interchangeably with the concepts of the "public sector" and the "public administration". This differs from the usage of the term in systems of national accounts, which vary according to the country. In France, for example, the "State" denotes a specific branch of the public administration identified with the central government and separated from other branches, such as local governments and social security entities. In other countries, such as Brazil, the term encompasses all segments of the public administration.

[35] See Lemoine (2018) for an insightful review of various interpretations of the "State" in social sciences and their contributions to examine the process of State financialization. In the period of financialization, dominant groups include investors and financial institutions. Several studies (Fastenrath et al., 2017; Lemoine, *op. cit.*; Schwan et al., 2020) demonstrate how public sector agencies, departments, ministers, and personnel working close to the financial sector have been gaining the upper hand over the remainder of the public administration during the past decades.

the private sector. It shows that the transformations occurring in the public sector in the period of financialization include, but are not limited to, promoting private sector financialization.

There is a fairly generalized perception that the mechanisms through which the State participates in the expansion of finance are related almost exclusively to its role as a regulator, promoting shifts that enable and encourage the expansion of financial markets (Pagliari and Young, 2020). The State is typically constructed as an important actor, facilitator, and promoter in fostering financialization (Sokol, 2017). The problem, according to Sokol (*op. cit.*), is that "*the literature on financialization has paid only limited attention to the way in which the State itself is increasingly subjected to the power of financial markets*" (p. 680). This second perspective could be explained, in the words of Schwan et al. (2020), as studying not only the process of financialization "*by* the State", but also the financialization "*of* the State". In a similar vein, for Chiapello (2017), there is the need to incorporate an approach to financialization that goes beyond an "*externalist view*" on the State, which looks at the financialization of the economy through public policies, but also an "*internalist view"*, concerned with the financialization of public policies themselves.

Wang (2020) offers an insightful account of the widespread misconceptions in the literature and the contributions of this recent body of works:

> Scholarly discussion on the rise of finance (…) tended to implicitly assume that finance expanded at the expense of the State. The contraction of the State was seen as symptomatic of a general net loss of political capacities (…). **We were reminded that everywhere we turned, public sectors were privatized, fiscal spending of the State was constrained, and government regulations were curtailed**. Losing assets and capacity, States were left toothless in the face of the rising global finance.
>
> (…) **The facilitation explanation treated State actions as external to the economy. It did not include state motives and political interests as forces in their own rights driving financialization.** In the past several years, a growing body of scholarship has emerged to call for an extensive and intensive examination of the state-finance nexus (…). **[It] shows states to be more than just promoters and facilitators of financial markets. States have used financial instruments and institutions to solve political problems associated with public finance.** (pp. 189, 190, 196, emphasis added)

Based on a collective reading, we can argue that the new relations between State and finance can manifest in at least two levels. First, the financialization of the State could be observed through shifts at the level of ideas and structures. The process of financialization is associated with a reformulation of the vocabulary, techniques, indicators, instruments, and institutional arrangements of public entities, which start mimicking those typically employed by financial companies. The creation of financial agencies and units within the public administration, the hiring of new staff from the private financial sector to work in them, and the "training" of existing public servants according to their views are just a few examples of how finance has "colonized" the public sector (Chiapello, 2017; see also Fastenrath et al., 2017; Fine and Hall, 2012; Karwowski, 2019).

Such shifts at the intangible level of ideas and organizational models shape public bodies' decision-making criteria in favor of measures that minimize financial costs and risks. Social costs and risks, in turn, are generally left out of the equation. They also make it seem possible, justifiable, and desirable to raise revenues in the private sector, touted as cheaper than traditional forms of funding. This creates an environment conducive to the resort to financial capital (Chiapello, 2017). Second, then, these seemingly subtle shifts can lead to transformations at the more concrete level of financing circuits – which includes how public entities raise money, from whom, and at what costs and conditions. Incorporating financial capital in public financing circuits means changing the ways in which public services, policies, and bodies are funded, introducing new instruments and strategies to bring in money that ultimately emanates from financial institutions and investors. This can occur, for example, when public entities issue securities, offer contracts that encourage investors to put money into specific projects, and create financial arrangements to pool money from different sources. Such innovations allow the public sector to mobilize funds voluntarily (as opposed to compulsory taxation on individuals and companies), and notably from foreign investors (Chiapello, *op. cit.*; Fastenrath et al., 2017).

The vast majority of what has been written about transformations in public financing in times of financialization has focused on *quantitative* trends, specifically the steady and significant rise in public debt levels. This rise is associated with the economic, social, and political changes that emerged along with financialization, and is considered to fuel the ongoing expansion of financial markets (Lemoine, 2016; Streeck, 2014). The literature on State financialization, in turn, calls attention to the vast array of *qualitative* changes underway. This includes the diversification of instruments to finance public policies, some of which were mentioned in the previous paragraph. Karwowski (2019) underscores the importance of considering this dimension, commenting that "*it is difficult to fully comprehend State financialization using quantitative measures alone, as major changes to fiscal and monetary policy have been qualitative in nature*"; for instance, "*it is not merely the size of public debt that indicates the presence (or absence) of financialization, but rather how debt instruments are designed, issued and managed*" (p. 1004; see also Fastenrath et al., 2017).

The literature on State financialization presents two main explanations as to why governments and public entities engage with financial instruments and institutions. Aalbers et al. (2017) frame them as "*constraint-driven*" and "*opportunity-driven*" financialization. The idea of constraint-driven financialization embodies the assumption that public entities adopt financially innovative techniques as an attempt to circumvent budget constraints in times of austerity (Karwowski, 2019; Quinn, 2017). Financial practices are interpreted as *"defensive measures*" (Løding, 2018, p. 4) in an era when public entities face increasing difficulties to obtain revenues from traditional sources. Apart from increasing income, the use of market instruments could also offer, at least in a first moment, other compelling advantages such as low interest rates (Dodd, 2010; Løding, 2018) and the opportunity to bypass regulatory constraints, as they allow to reallocate revenue and spending items across the public budget (Chiapello, 2017; Lagna, 2016; Quinn, 2017; Whitfield, 2015). Following this line of reasoning, it can be argued that austerity would favor not only a more residual

approach to public policies but also new strategies to finance them, as this context imposes limits to usual sources of revenues and stricter budget rules on public entities.

Even Schick (2013), who departs from a rather positive view on the use of private finance by public entities, acknowledges the potential for using these strategies to bypass regulatory constraints. He writes that, on some occasions, welcoming private capital

> (…) can be a means of **evading fiscal constraints by shifting expenditures off the budget**. In many cases, contingent liabilities can substitute for direct expenditures, but with the **critical difference that the latter are recognized on financial statements and the former usually are not**. For example, governments (…) can directly finance road construction through budgeted expenditures or through off-budget guarantees embedded in Public-Private Partnerships. **The choice of policy instrument is not driven solely by efficiency considerations, but is strongly influenced by how various arrangements are treated in the budget** (*op. cit.*, p. 48, emphasis added).

Opportunity-driven financialization, in turn, reflects the idea that the observed transformations in public finances are considered a result of public entities seizing opportunities to generate income and conduct statecraft in ways that were previously inaccessible to them (Lagna, 2016; Løding, 2018). Aalbers (2019) contends that these two sets of explanations are not necessarily opposed, suggesting that the reality seems to be better understood as a "bricolaged" response to both fiscal constraints and financial market euphoria.

We can distinguish at least four particularly prominent research themes within the current research on State financialization. These are focused on how financialization has changed the workings of central governments, local governments, public investment institutions, and areas of social provision. Considering that these spheres are all directly or indirectly involved in the organization, financing, and service provision of PHS, understanding how financialization reshapes them can bring valuable insights to our discussion.

Financialization and central governments: changes in public debt management

The so-called "financialization of government debt management" is arguably the most researched topic in the literature on State financialization (Fastenrath et al., 2017; Lagna, 2016; Lemoine, 2018, 2016; Pagliari and Young, 2020; Preunkert, 2017; Schwan et al., 2020b; Wang, 2020). At the heart of this transformation is the marketization of the public debt – the process through which governments started borrowing from financial investors in global financial markets instead of relying on administered sources of funding. The central agent driving these transformations is the central government, which issues these securities to finance itself and refinance its debt (also known as "sovereign debt").

As described throughout these different accounts and exemplified in our descriptions of the financialization process in France and Brazil, until the 1960s, States financed themselves by borrowing from individual agents and issuing their debts in the form of bonds

with politically controlled interests and to targeted buyers, with whom they negotiated directly. This form of financing can be referred to as "classical debt". It implied stable, long-standing relationships with creditors, who provided loans or purchased bonds intending to hold them to maturity. Along with the beginning of the financialization of the world economy in the 1970s, there was a structural shift in the way that governments raised revenues and refinanced their debts. This went from borrowing from specific lenders via long-term arrangements to selling public bonds to financial investors in order to raise funds. The novel approach allowed governments to raise funds from financial investors willing to buy these securities, both national and foreign. These securities consist of negotiable assets, meaning that investors are not obliged to hold them until maturity, but can sell them at a profit at any time. Issuing bonds quickly became the primary means of government financing, accumulating what is sometimes referred to as "financial debt".

The financialization of the public debt is marked not only by a shift in the instruments used for public debt management but also by the changing balance of power between the State and its creditors as a consequence of such a shift. The public debt ceased to rely on non-tradeable obligations enforcing a stable bilateral relationship between the State and individual creditors; instead, it became a tradeable financial product that could be bought and sold on financial markets to make short-term assets (Preunkert, 2017). The marketable bonds are sold at auctions and have their interest rates influenced by the conditions of supply and demand in the markets. As highlighted by Lemoine (2018, 2016), this means governments are deprived of their power to regulate the volume and cost of their own financing. By issuing securities to obtain funding, States become market creators and players (Karwowski, 2019; Pagliari and Young, 2020). At the same time, global financial actors acquire the power to influence their decision-making processes, determining the availability and costs of government financing (Fastenrath et al., 2017; Preunkert, 2017).

Blakeley (2020) goes over some of the chief mechanisms through which markets manage to gain influence over governments through the channel of the public debt, as well as the role played by austerity ("fiscal rectitude") in this process:

> Part of the reason governments considered such a demonstration [of fiscal rectitude] necessary is that they needed private investors to believe that they will honor their debts. Demand for government debt is inversely correlated with yield: the higher the demand, the lower the interest payments. This gives the markets power to discipline states that fail to demonstrate a commitment to creditworthiness. States that fail to implement neoliberal policies can be punished through bond selloffs and runs on their currencies, giving international investors significant power to influence democratically elected governments. It doesn't matter that forcing States to implement neoliberal economic policy actually reduces their creditworthiness over the long term; the time horizons of financial capitalism are shorter than at any other period in history. (pp. 7-8)

Issuing debt instruments in financial markets would offer governments the possibility of expanding the scope of revenue sources, especially by reaching out to foreign investors (e.g., Plihon, 2003). It could also reduce debt costs due to the assumption that competition among lenders would lower the interest rates charged to provide funds (Fastenrath et al.,

2017; Karwowski, 2019; Preunkert, 2017). A number of authors put these immediate explanations into perspective, suggesting that this shift in public financing should be understood as part of a far deeper transformation in the relations between States and financial markets in the context of the financialization of the world economy. This expanded reading on the State's approach to public debt management in times of financialization contributes to our discussion as it sheds light on the ultimate pressures leading it to turn the markets and the consequences of such a shift for public spending.

Streeck (2014, 2013) identifies three main paradigms governing States' approach toward public financing, expenditures, and debt management over the past centuries. Until the post-war period, governments relied on taxation as their primary source of funding, configuring the so-called "Tax State". Amidst the rise of neoliberalism in the 1970s, the declining taxation on capital and the globalization of production shrank the relative volume of public revenues, leading States to face growing financing needs. Seeking to conciliate profit incentives with social demands, governments "*came to rely on borrowing from elites instead of taxing them*" (Hager, 2016, p. 7). They carried institutional reforms to raise a greater volume of funds through the process of marketization of the public debt and started borrowing at a much faster pace. This marks the emergence of the "Debt State", a State that finances itself increasingly through debt borrowed in the financial markets. Such developments were contingent on the financialization of the economy, including the deregulation of financial markets, their geographic integration, and the enormous expansion of their institutions and instruments. At the same time, creditors started a permanent onslaught to maintain a political-economic arrangement favorable to States' continuous indebtedness.

Streeck also argues that the continuous growth of public debt amidst a context of heightened global instability, especially since the late 2000s, has steered governments into a slightly different direction. Creditors started calling for implicit and explicit guarantees of governments' capacity to honor their debts. Among them, there are the pressures to implement "fiscal consolidation" policies – i.e., measures to reduce the fiscal deficit and the debt-to-GDP ratio (Ortiz et al., 2015). This context set the stage for the "Consolidation State", marked by government attempts to stabilize and bring down the public debt. One thing, however, seems to have remained the same during these two last stages of public debt management, the prioritization in the use of public resources to service the public debt.

Lemoine (2018, 2016) also discusses why and how States prioritize the use of funds to serve the public debt rather than financing social provision, as well as the ways in which this is connected to the financialization of the world economy. The author suggests the concept of the "Debt Order" to describe the formation of "*a political society that makes sacred the credit of the State vis-à-vis financial investors*" (2018, p. 316). This approach is aligned with the ideas presented in the previous paragraphs in the conviction that financialization is linked to a particular mode through which governments operate, subordinated to financial markets. One can find fundamental differences between Streeck's and Lemoine's approaches in that the latter puts greater emphasis on the variegated ways in which this approach to public debt management affects different sectors of society. Beyond differences in focus, however, both authors contribute to understanding how the

hierarchization of public policy priorities in favor of creditors brings direct implications for fiscal policy.

Under the "Debt Order" (or, alternatively, the "Debt State" and the "Consolidation State"), governments must save funds to honor their debts (i.e., pay for interests and amortizations). In a political setting averse to increasing taxation, especially on capital, these revenues come mainly from cutting spending in areas other than the public debt service, notably investments and social expenditures. These are the most common measures carried by governments to save funds for public debt repayments and reassure the markets about their creditworthiness (see also Deruytter and Möller, 2020; Sokol, 2017). Another common type of reform to save funds for public expenditures consists of regulatory shifts that impose legal constraints on public spending, such as balanced budget amendments to the national constitution (Deruytter and Möller, 2020; Streeck, 2013).

It is worth noting that these shifts in State financing accompanying (and boosting) the financialization of the world economy entail not only a particular paradigm of fiscal policy, but of monetary policy as well. The standard approach to the latter in the current period also seems to prioritize the interests of financial investors (and impose constraints on public spending to do so). The literature on the *modus operandi* of financialized States mentioned above (Lemoine, 2018, 2016; Streeck, 2014) highlights that fiscal policies typical of the financialization period are accompanied by a specific orientation to monetary policies focused on fighting inflation. The fight against inflation is crucial for preserving the social and political order subordinated to global financial markets. As explained by Epstein (2001), financial profits are positively correlated to asset appreciation and negatively affected by price inflation. In more simple terms, this means that price stability preserves the value of financial assets, while inflation erodes it once the currency loses its value (see also Karwowski, 2019; Lemoine, 2018; Palley, 1997). Especially in the case of developing countries, this concern with inflation often reinforces high interest rate policies, which take a heavy toll on the public budget (Becker et al., 2010).

The consolidation of a "pro-finance" monetary policy framework became evident in the 1990s, as a growing number of central and peripheral economies started adopting inflation targeting policies. This means establishing a low inflation goal and directing monetary policy to achieve it, almost always to the exclusion of other goals such as reducing unemployment or stimulating investments (Epstein, 2001). Tellingly, the inflation targeting framework takes into account the inflation of general prices while leaving aside financial asset inflation (Karwowski 2019). This indicates that "*central banks across the globe have internalized the financial motives of private investors and creditors through inflation targeting, aimed at preserving the value of financial investments"* (p. 1017). Empirical studies support this argument by confirming that the only effect of inflation targets over the past decades has been to curb inflation, with no significant improvements in other macroeconomic aggregates (Epstein, 2001; Epstein and Yeldan, 2008). In light of these results, these studies conclude that the explanations for the spread of inflation targeting regimes over the last decades are to be found in "*the increased power of rentier interests which have been promoting inflation targeting and central bank independence as ways of*

keeping inflation low”, which consequently “*increase the share of income going to rentiers*” (Epstein, 2001, p. 5).

From what has been exposed so far, it becomes clear that the marketization of the public debt, tight fiscal policies, and anti-inflation monetary policies go hand in hand, consolidating a form of governance where the interests of creditors are placed above those of other agents. In our case studies, it will become clear how such developments imposed unprecedented challenges for the financing of public health and favored the financialization of PHS.

Emerging themes on State financialization: local governments, public investments, and social provision

Among emerging themes in the literature of State financialization, one of the most rapidly growing areas of research is the one on local governments. The research on the “financialization of local governments” (Ferlazzo, 2018; Løding, 2018) calls attention to the fact that local and regional governments are engaging in new relations with the financial system. In particular, they are employing strategies to raise and manage funds independently from central government. Case studies and reviews on the topic identify these developments in instances where these governments issue their own bonds, capitalize future income streams from public services and utilities, engage with derivatives and off-balance sheet transactions, use local revenues to invest in financial markets, and contract structured loans (including “toxic loans”), to mention a few examples (Aalbers, 2019; Beswick and Penny, 2018; Deruytter and Möller, 2020; Dodd, 2010; Løding, 2018; Wang, 2020).[36] The fact that local governments in both France and Brazil are experimenting with financial innovations demonstrates how quickly this phenomenon is spreading across the globe. For example, French “local communities” have been issuing bonds and engaging in structured loans (Ferlazzo, 2018), while Brazilian municipal governments (*governos municipais*) are increasingly interested in securitizing local tax revenues (Fattorelli, 2017).

Aside from governments, two research areas attracting considerable attention in recent years are those looking at the impacts of financialization on public investments and service provision. In the case of investments, studies note that bodies responsible for managing public assets and investing public funds have been relating differently to financial markets, practices, and institutions over the past years (Dixon, 2020; Schwan et al., 2020b; Wang, 2020, 2015). This novel approach for public investment and asset management could be observed by looking at State-run investment funds, State-owned enterprises, and bodies responsible for managing State assets, to mention a few examples. There is growing evidence that some of these entities are behaving similarly to private shareholders and institutional investors, making decisions that prioritize shareholder value maximization or increase the share of revenues coming from financial investments. Wang’s (2015) concept of the “*shareholder State*” is particularly illustrative of the nature of such shifts, describing a State

[36] Some authors also call attention to the use of such instruments by central governments, although in this case the research is mostly focused on derivatives and swaps (e.g., Fastenrath et al., 2017; Lagna, 2016; Schwan et al., 2020).

that has "*refashioned itself as a shareholder and institutional investor in the economy and resorted to financial means to manage its ownership, assets, and public investments*" (p. 1).

To end, we reach the area of social provision. The literature on State financialization also opened an avenue of research into the transformations taking place inside the public entities that organize the financing and delivery of social services. These include governments, ministries, social security institutions, specialized agencies, and other bodies directly or indirectly responsible for policies related to health care, education, pensions, housing, and other realms related to social reproduction. Given that these are an integral part of the public sector, this approach also considers whether and how these entities are leaning toward financial instruments and strategies to carry out such activities. Wang (2020) captures the essence of these developments observing that "*welfare state institutions moved closer to financial markets"* as *"State agencies for pensions, housing, education, and health care have invested in the market, borrowed from the market, and subsidized market-based financing*" (p. 190).

Initially, the investigation on how financialization reshapes the ways in which public entities finance and organize social provision paid particular attention to the areas of pensions and housing (Bayliss et al., 2017, 2016b; Fine, 2014, 2009; Karwowski, 2019).[37] The role of household credit as a means of accessing housing, in the first case, and the shift from public risk-sharing pension schemes to increasingly individualized fully funded schemes, in the second, have been presented as particularly prominent aspects of financialization in social provision. This is not to say that these have been the only sectors under investigation, but simply that they seem to have been the object of more continuing research over time, especially in earlier stages of research. This focus is understandable; the own nature of these services makes them relatively more dependent on financial intermediation than other sectors (even if sometimes subject to State regulation), which contributes to making new relations with financial markets more evident in these cases. In contrast, there seems to be less published research on how the financing of activities in sectors of service delivery, such as public health and public education, might have been subjected to financial practices, institutions, and markets.[38]

Over the last decade, academic research began to pay greater attention to a number of financing instruments that allowed broadening of the research on the financialization of social provision. We can highlight, for example, public-private partnerships and social impact investment (e.g. Andreu, 2018; Bayliss and Van Waeyenberge, 2017; Bryan et al., 2020; Karwowski, 2019; Whitfield, 2015). Public-Private Partnerships (PPPs), mostly used for infrastructure financing, consist of long-term contracts between the government and private actors in which the latter assumes part or all the financing, building, and operational tasks of a public project. Financial actors participate and profit from PPPs in different ways;

[37] Although some of these works are not explicitly informed by the theory of State financialization, they have been important to bring awareness to the field. While part of them suggests that the largest amount of research is dedicated to pensions, there is reason to argue that the research on the housing sector has also received a great deal of attention (see, e.g., Aalbers et al., 2020, 2017; Bayliss et al., 2016a; Beswick and Penny, 2018; Wijburg and Waldron, 2020).

[38] The existing research for health care will be discussed in chapter 2.

for example, banks, investments funds, and investors can provide credit, acquire assets, or even securitize income flows to create securities traded in secondary markets (Bayliss and Waeyenberge, 2017; Loxley and Hajer, 2019). Social Impact Bonds (SIBs) and other variations of "social impact investing" are used to finance specific interventions, raising funds from investors against future repayments and compensations based on results (Andreu, 2018; Lavinas, 2018b; Ryan and Young, 2018). In both cases, these strategies allow financial investors to provide upfront financing for public actions in several areas related to social provision.

Given the diversity of social policy across place, time, and program (Bayliss and Fine, 2020; Fine, 2014, 2009), understanding how public entities are turning toward finance to maintain social provision requires systematic and in-depth investigations for a wide scope of countries, sectors, and strategies. In the remaining part of this thesis, we contribute to this task by delving into the case of health. We will further unpack how PHS are responding to the constraints they face in the period of financialized capitalism and how they are drawing on the growing array of solutions offered by the financial sector to do so.

CHAPTER 2. PUBLIC HEALTH SYSTEMS IN TIMES OF FINANCIALIZATION

During the 20th century, several countries recognized health care as a fundamental right and instituted public health systems (PHS). Since then, these systems have expanded both in terms of service and population coverage, reflecting their centrality as a mechanism to promote social well-being. This successful trajectory, however, seems to be increasingly questioned and reversed. To understand the challenges faced by PHS today, it seems crucial to look at the processes of financialization. This can be explained in light of the fact that it is virtually impossible to describe current transformations in the health sector without mentioning financial actors and instruments. Considering that public systems are responsible for a significant, often the largest share of health care financing and provision in each country, the rampant expansion of finance will most likely influence the direction taken by such systems in the 21st century.

In order to examine how financialization is reshaping PHS, this chapter seeks answers to two key and still open questions: One, what does it mean to say that a PHS is undergoing a process of "financialization"? Two, how to contextualize this process in the long-standing path of health system transformations in the neoliberal era? We can argue that the fresh perspective offered by the concept of financialization can provide a clearer view of the instruments and strategies through which part of reforms in PHS (especially from the 1990s onward) have been implemented. It can also shed light on who are the agents that have been driving and profiting from such shifts, as well as the potential implications for the operation of PHS.

The first section of this chapter introduces the topic of PHS, clarifying to which institutions we are referring and the main institutional arrangements worldwide. The second section systematizes the most common terms that have been used to examine neoliberal reforms in PHS. It will also highlight the limitations of the traditional literature on health systems change, in particular the lack of in-depth analyses of financialization. The final section recovers the concept of financialization and elaborates on how we could apply it to examine reforms in PHS. To conceptualize the process of financialization in PHS, we draw insights from two sources: one, the existing literature on financialization in global health policies and private health activities; and two, our own systematization of evidence on how public health activities, especially in countries with comprehensive public provision, have become more dependent on financial instruments and markets. We contrast these latter developments with the shifts typically associated with the notion of privatization, contending that they reflect a distinctive type of PHS reform aligned with the idea of financialization. The working definition and typical features of financialization in PHS suggested here offer a common analytical grid for the empirical investigation carried out in the upcoming chapters.

2.1. Public Health Systems (PHS)

2.1.1. Reasons for State intervention in health care

State intervention in health care can be justified on both moral and economic grounds. Starting with the *moral case* for intervention, it is often the case that "*societies, for generally accepted ethical reasons, decree that certain commodities [sic], which in principle are readily marketable, should be excluded from the usual economic calculus*" (Barr, 1998, p. 291). Health goods and services are a chief example. From an ethical and moral standpoint, there are compelling arguments to explain why nations would agree with State intervention in health markets. First and foremost, physical and mental health are critical for individuals to be able to live, function as agents, and fully explore their potential as human beings (Sen, 2004, 1992). Not by chance, individuals and societies often express greater concern with inequalities in health than with inequalities in the distribution of income or regular commodities; the former constrain what people can be and do, representing inequalities in the most basic freedoms and opportunities that people can enjoy (Anand, 2004).

Adding to the intrinsic value of health and health care, there is the realization that individuals may lack the opportunity to access a good state of health not out of personal choices, such as due to the lifestyles they adopt, but as a consequence of factors beyond their control (Sen, 2004, 1992). The latter include the political and economic structures, processes, and power relationships of modern capitalist societies. As reminded by Schrecker (2020), these forces shape the conditions in which people live and work; in doing so, they enable healthy lives, or, conversely, sicken, disable, and kill.

The importance of health and the existence of differences in health conditions created by the external forces would give good reason for State intervention in health. This can be justified as a means to guarantee that individuals can receive the assistance they need regardless of factors considered irrelevant from a moral standpoint, such as personal income or occupational status (Barr, 1998).

Besides reasons related to morality and social justice, there are also economic reasons that can justify the status of health as a "special good" and legitimate State action to organize its distribution. The *efficiency case* for State intervention in health care is based on the argument that the conditions that would be necessary for unregulated private markets to function properly do not hold when it comes to health goods and services. Barr (1998) points to several distortions commonly seen in private health markets that undermine efficiency – i.e., the allocation of resources that could bring the greatest improvements to health at the national level. He recalls that the assumption of private markets efficiency depends on a number of conditions including perfect information, perfect competition, and the absence of market failures. Health care activities, however, fail to meet these conditions in several ways. There are, for example, serious information problems caused by the inherently unequal levels of power and knowledge between health providers and patients. Similarly, several aspects undermine perfect competition. It is no exaggeration to state that obtaining health assistance is often a matter of life and death. It is difficult to argue that individuals can make "rational choices" between service providers when decisions are surrounded by a heavy

weight of emotions, fear, and urgency. There are hardly any other sectors where the so-called "rational consumer choice", so dear to advocates of private markets, is as compromised as in health care.

One can make a similar case with the conditions that are necessary for insurance markets to work – that is, for a member to be compensated without compromising the stability of the fund. Drawing on arguments first presented by Arrow (1963) in his classic paper on uncertainty in health care, Barr (1998) lists several reasons why free private health insurance would be prone to gaps and inefficiencies. These have mainly to do with the fact that private insurance is governed by the logic of actuarial accounting, based on estimations of individual risks. For private schemes to work, those risks must be assessable, independent among members, and less than one (i.e., they *may* or *may not* occur). In the case of health insurance, fulfilling these requirements may be difficult or even impossible. This is due to a variety of reasons, such as the difficulties of estimating individuals' health care needs in the long run (and thereby their risks), the existence of interdependent risks (such as in the event of epidemics), and the many events in which the need for insurance is certain (as in the case of chronic illnesses, for example). To cope with distortions, private insurers tend to charge high-risk individuals more and resort to practices known as "cherry-picking" or "cream-skimming", refusing to cover them. These gaps in conventional medical insurance coverage are particularly harmful to the most vulnerable individuals, often failing to protect risks related to complex and long-term diseases, the medical needs of the elderly, and collective health services, to name a few.

These many distortions across service and insurance markets explain why "*there is an overwhelming presumption that an unrestricted private [health] market will be highly inefficient, and also inconsistent with widely held notions of social justice*" (Barr, 1998, p. 317). Only the State would be able to jointly promote equity and efficiency in health care due to its unique capacity to regulate activities, organize production, and redistribute resources in the economy.[39]

Such distortions can also help to understand why most industrialized countries have chosen to not rely on private payments and insurance as the primary method of health care financing. Instead, public entities formally assume the responsibility to protect the population against the risks of disease and the costs of health care treatments, providing every citizen or resident with access to service provision or insurance. The public arrangements that have been created to do so underpin our concept of PHS (sections 2.1.2 and 2.1.3 below). In practice, it is virtually impossible to determine how much moral and economic factors have each contributed to the creation of real-life public systems; following Barr (1998), it seems more reasonable to argue that both forces exerted some sort of influence. As the author concludes when weighing the reasons for the creation of "welfare states" over the 20th century (which are directly related to the creation of PHS), economic factors seem to have played a role once "*industrial countries face similar problems, so it is not surprising that many have adopted broadly similar solutions. (...) Similarly, the*

[39] The "State" means here the government or other public entities, such as social security agencies and local authority bodies (see chapter 1 for the usage of the term in this thesis).

technical problems with private markets (...) afflict all industrialized countries"; but moral imperatives also appear to have influenced this process, "*if only in determining whether a country adopts a residual or an institutional model*" of State intervention (p. 41).

2.1.2. Defining public systems

A health system can be defined as the ensemble of institutions, resources, and people involved in the financing, organization, and delivery of health services at the national level (WHO, 2010a). Every country has a unique health system, which reflects its history, level of economic development, and dominant political ideology (Roemer, 1993). Although the literature presents numerous proposals for classifying and characterizing national health systems, there is no commonly agreed upon definition of public health system or set of criteria to identify it (Jarvis et al., 2020; Papanicolas, 2013; Stuckler et al., 2010). Jarvis et al. (*op. cit.*) assess 67 studies on public health systems to find that only twenty of them have formally defined the term, half of the time proposing a new definition.

The challenges for delimiting the boundaries between public and private in health care can be understood by considering the very notion of "system"; as the term suggests, the organization of health care services at the national level depends on the coordination between several parts of the public and private sector, including the government, public bodies, non-profit entities, private for-profit companies, health professionals, and users. Each country will end up with a unique combination of these elements. Moreover, these agents will work under particular forms of cooperation and competition in each case. In light of these factors, the boundaries between public and private tend to be more blurred in the case of health care than in most other sectors (André et al., 2015; André and Hermann, 2009).

In this work, we define public health systems broadly to encompass all health systems organized by the public sector and informed by the principles of universality, equity, solidarity, and comprehensive care. We consider that a system is organized by a public entity when the government or another public body assumes the central role in the management and financing of services. The principle of universality establishes that the system covers the entire population of a country, legally entitled to receive health care through insurance coverage or direct service provision. The notion of equity implies that all members have access to the same standards of services, delivered according to medical needs rather than the capacity to pay. Solidarity means that the system's financing is based on compulsory taxation (e.g., income taxes and contributions on wages), which would allow each individual to contribute according to their means. Comprehensive care denotes the State's commitment to cover services at all levels of complexity, comprising the full spectrum of actions individuals may need – from prevention to treatment and rehabilitation. Additionally, these systems are formally inscribed in the national constitution or relevant legislation, and therefore their existence is relatively shielded from the dispositions of incumbent governments. Several central and peripheral countries present health systems that fit into these criteria, with varied institutional arrangements and at different levels of consolidation in each case.

PHS represent the main gateway to services for the majority of the population in the

countries in which they exist. Moreover, they have a unique capacity to mitigate inequalities and exclusions of access typically observed in countries dependent on private financing and provision. Studies show that nations with comprehensive and compulsorily financed systems tend to present lower levels of health care inequalities, greater efficiency in resource allocation, superior indicators of population health, and lower levels of total health spending compared to countries reliant on private and poorly regulated markets (Agartan, 2012; Giovanella et al., 2018; Mackintosh and Koivusalo, 2005; WHO, 2010b; Yi et al., 2017). They also foster a shared sense of community and protect citizens from financial calamity in the event of a medical crisis (Dao and Mulligan, 2016). The relevance of universal systems transcends national frontiers, as they serve as blueprints for countries still in the process of establishing universal access to health care.

2.1.3. Common institutional arrangements

The different paths taken by each country to organize the provision of health services and insurance led to a vast body of literature seeking to classify health systems (Beckfield et al., 2013; Böhm et al., 2012; Rothgang, 2010a; Toth, 2016; Wendt, 2009; Wendt et al., 2009). This research field adopts an international comparative approach to cluster different experiences and identify "health system types" – theoretical constructs grouping experiences that resemble each other on some key points. While there is hardly ever a perfect fit between ideal constructs and real-world systems, ideal types represent close approximations that allow for a better analysis of reality (Rothgang, 2010a).

Financing and provision are the two main dimensions that differentiate health systems (see e.g., Beckfield et al., 2013; Wendt et al., 2009). The dimension of financing considers the way in which the system is funded – how much it raises in revenues, how these are collected, and where it spends them. The dimension of provision takes into account the organization of the scheme – the arrangement established between public and private entities to offer services.[40] Rothgang (2010) includes regulation as a third important dimension to classify health systems. As illustrated by the author, "*health care systems can be visualized as a house, with financing and service provision as its two pillars resting on a foundation of shared values (...) and with the roof representing the regulation of the interactions between service providers, financing agencies, and potential beneficiaries*" (p. 11).

The several roles of the State in health care can be conceived within this three-dimensional framework comprising financing, provision, and regulation. First, the State can, to a greater or lesser extent, finance services and insurance. Second, it can act as a provider of services. Lastly, even if it does not finance or provide services directly, it can be more or less engaged in the regulation of other actors. The degree and forms of State intervention along these lines are the main criteria used to distinguish health systems (Roemer, 1993;

[40] Conventionally, in the health systems literature, "public entities" include government units, public sector institutions, and social security branches, while "private entities" include mutual companies, for-profit insurers, not-for-profit insurers, and sickness funds, among others (OECD, 2004).

Rothgang, 2010a).

Once unregulated activities lead to distortions both in health services and insurance markets, the two primary models of PHS that have been created to achieve universal and equal access to care are based on public provision (direct public service delivery) and public insurance (collective and regulated insurance schemes). There is now a vast number of works distinguishing ideal national health systems types (see, e.g., Böhm et al., 2012; Freeman and Frisina, 2010; Rothgang, 2010; Wendt et al., 2009). Although each work proposes a unique form of classifying these systems, it is common practice to distinguish three ideal types: the "national health service", the "social insurance", and the "private insurance" model.[41] The breakdown of health care systems into these three models is the standard typology that most authors have been sharing and using as a basis to conduct their analysis and formulate more detailed classifications (Toth, 2016). Despite its value as an analytical tool, this customary tripartite classification has been criticized for oversimplifying the differences among health care systems. Several authors have sought to better capture national specificities by broadening the scope of possible arrangements and empirically testing how real-world systems fit into them (e.g., Moran, 2000; Reibling et al., 2019; Toth, 2016; Wendt, 2009; Wendt et al., 2009).

Drawing from the systematization developed by Rothgang (2010; Rothgang et al., 2005), each model works according to the following overarching logic:[42]

i. In "national health service" models, the government is directly responsible for health care financing and service provision. The system is financed through the government budget, mainly from general taxation. Services are publicly provided, free at the point of delivery, and the providers are government employees or contractors. The underlying value is equity: every citizen should enjoy equal access to care. These systems are sometimes referred to as "Beveridgean systems" after William Beveridge, the British civil servant and politician whose ideas influenced the creation of the first system of this type in the United Kingdom. The country continues to be the main reference for national health service models; several other countries followed the same path, such as Sweden, Norway, Denmark, Finland, Iceland, New Zealand, Italy, Portugal, Spain, Brazil, and Cuba.

ii. In "social insurance" models, societal actors take on the responsibility for health care financing and provision. Societal actors are defined as non-governmental actors entrusted with responsibilities to support the general public interest (Frisina et al., 2021). The system is financed through mandatory insurance funds managed by these actors. The bulk of revenues comes from social contributions (typically payroll taxes paid by employers and employees). These social health insurance funds represent a collective form of financing, allowing for resource redistribution, as well as collective management, with mechanisms allowing members to take part in decision-

[41] Some scholars (e.g., Beckfield et al., 2013) also mention a fourth type of health system, the *Semashko* model. This was the typical model of soviet countries, based on universal health care fully funded and provided by the State.

[42] See also Hermann (2010) for institutional features, Serapioni and Tesser (2020) for empirical examples, and OECD (2004) for technical definitions.

making processes. The government may participate in the overall financing of the scheme, regulate conditions of access and the value of premiums, and guarantee the benefits. Service provision is also considered societal. It comes from a mix of public and private entities, usually with important participation of non-profit providers. Private professionals and establishments are also subject to considerable government regulation, which can, for example, control the price of services. The underlying value is solidarity: equal access to services for all members of the fund. These systems are also known as "Bismarckian systems" in reference to Otto von Bismarck, the German chancellor who first instituted a mandatory national health insurance. Germany remains the archetype of this model; other countries that implemented mandatory insurance include France, Belgium, the Netherlands, Japan, Switzerland, Canada, Taiwan, and South Korea.

iii. In "private health care" models, market actors control health care financing and provision. Private financing comes in two ways: from private insurance premiums and out-of-pocket payments. Service provision is in private ownership, from both for- and not-for-profit providers. There is no or limited government regulation on private sector prices and insurance coverage. Different from the social insurance model, insurers have much more freedom to select beneficiaries and adjust premiums according to risks. The underlying value is equivalence: services are provided according to the ability to pay for them. Although mandatory or State-sponsored health care schemes may exist in countries that follow this model, they do not cover the entire population and provide varying degrees of protection across the schemes. The United States is the only large, high-income country in which this model continues in place, while Chile is a case in point in peripheral countries. In general, we can infer that any country that does not count with significant State intervention on service provision or insurance will fit into this category.

Our notion of PHS encompasses systems following either one of the two first categories described above – national health service and social insurance models. This is because, over time, countries following both approaches have been able to enforce principles of universality, equity, solidarity, and comprehensiveness in health care. That countries following either one of these models have been able to universalize health care coverage can be explained in light of the process of (partial) "convergence" between these models in recent decades. The idea of convergence is used in the health systems literature to describe that, since the late 20th century, countries with national health service models have been incorporating features typical of social insurance models and vice-versa, including in terms of financing, spending, and regulation, giving rise to much more "hybrid" systems (Rothgang, 2010b). Countries with social insurance systems have progressively implemented universalization measures so that all citizens (and not only those with a formal labor contract) could be incorporated into collective insurance schemes (Abecassis et al., 2017; Barbier and Théret, 2009; Batifoulier, 2015). As insightfully put by Palier (2010a), this can be described as an attempt to "*reach Beveridgean goals through Bismarckian means*" (p. 97). Nevertheless, we characterize it as a process of "partial" convergence given

that the original institutional features of each group were largely preserved over the course of this process (Fine, 2014; Palier, 2010b; Palier and Hay, 2017).

Classifications of health care systems have taken a comparative-institutional perspective that connects them to the welfare state literature and its attempts to classify different types of welfare states (Esping-Andersen, 1990).[43] However, several scholars critically remark that areas of service delivery, such as health, have been relatively neglected in the welfare systems research to the detriment of areas related to monetary transfers, more specifically pensions and assistance benefits (Bambra, 2005; Freeman and Frisina, 2010). This makes the literature on health care systems types a crucial strand of research to capture the specificities of State intervention in health.

2.1.4. PHS in historical perspective

Up to this point, we have covered the technical aspects of State intervention in health and the objective criteria used to classify health systems. It is also important, however, to consider how this applies in practice. This section briefly describes how public systems emerged and how they have evolved from their early years until the present day.

Any attempt to place a start-point on public health history is bound to be arbitrary (Gorsky, 2011). The beginning of public health policies, in the sense of collective actions that prevent or alleviate diseases, could probably be traced back to the start of human civilization. Looking at modern history, the sources of health care assistance until the 19th century varied from one country to another, but most often included private services from liberal professionals acquired via direct payments, voluntarist and charitable work, and financial support provided by self-help associations such as mutual aid societies (Immergut, 1992; Porter, 1999). Public health policies, when available, were residual, fragmented, and uncoordinated, failing to reach the majority of the population.

States became increasingly involved with health policies since the beginning of the industrialization period in the 19th century. The greater concern with the health conditions of individuals and communities from this time on has been explained in light of both material and ideological developments accompanying the formation of industrial societies. Some factors frequently mentioned to explain the growth of public health policies include the detrimental impacts on the living conditions of the population brought by industrialization and urbanization, medical discoveries, the rise of working-class movements and socialist ideals, and a more generalized concern for social justice and decent living standards. Overall, there has been an increasingly widespread recognition that the advance of industrial capitalism imposed a specific set of risks that threatened individual and social life and needed

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[43] As discussed in chapter 1, "social protection systems" or "Social Security systems" refer to the legal and institutional framework that seeks to ensure all citizens can satisfy basic needs and access certain essential services. In practice, this generally involves the provision of old age pensions, social assistance benefits, and health care (through PHS). The idea of "welfare state" encompasses a wide range of State interventions aimed at improving the population's well-being, including not only social policies such as those previously described but also policy interventions in other areas, such as via tax, monetary, and occupational policies (Barr, 1998; Esping-Andersen, 1990; Lavinas, 2018a; Titmuss, 1956).

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to be dealt with. Meanwhile, the rise of "Nation States", with the unification of countries and the centralization of political powers, meant that authorities were also more capable of planning, financing, and implementing public health interventions (Valin and Meslé, 2006; Barr, 1998; Gorsky, 2011; Porter, 1999). Governments started to actively engage in collective and individualized policies to counteract pandemics, diseases, and workplace injuries. These include sanitary policies and vaccination programs, the enacting of workplace regulations, financial and regulatory support to mutual insurance funds, and the creation of public hospitals, to mention a few (Bryant and Rhodes, 2020; Goldsteen et al., 2010; Gorsky, 2011; Tulchinsky and Varavikova, 2014).

Over the past one and a half century, several nations started to express greater concern with equity, solidarity, and widespread access to health care. This could be perceived in the efforts to institutionalize national and mandatory arrangements to finance and provide health care services. The creation of PHS resulted from the gradual extension of the scope of State intervention through both legislative measures and the creation of public programs to organize health insurance and service delivery (Maarse, 2006). Europe pioneered the creation of public systems. Lobato and Giovanella (2012) identify three moments that marked the constitution of the first expanded systems of health protection in the continent: at the end of the 19th century, a first wave of legal reforms extended government subsidies to voluntary mutual societies in various countries of the region; in the first decades of the 20th century, a second wave led to the creation of social health insurance models, disseminating the German experience with a national compulsory health insurance introduced in 1883; following World War II, a third wave of regulations universalized the right to health care and created universal systems (see also Immergut, 1992 and Lewalle, 2006). In some countries, principles of universality came with a paradigmatic shift, with governments establishing free public health provision (the path typically followed by national service models); in others, it was the result of successive measures to expand the eligibility for insurance coverage (the case of social insurance models).

The developments described so far focused on the wealthiest and most industrialized economies, which spearheaded the creation of PHS. But peripheral countries also embarked on this process. Several of them extended social protection benefits and health care policies during the 20th and early 21st centuries. Looking at the history of national health systems in Latin America, Giovanella and Faria (2015) and Laurell and Giovanella (2018) show that some countries in the region introduced Bismarckian systems of social protection still in the 1930s and 1940s, leading this process in peripheral countries. In the following decades, public coverage was extended to rural and deprived areas under the influence of "health for all" proposals and the Beveridge model. Chile was the first country to set up a national health care system in the 1950s, inspired by the British model (later dismantled under the Pinochet dictatorship). In 1988, Brazil instituted a national health service system. Following its steps, Venezuela (1999), Ecuador (2008), and Bolivia (2009) promulgated constitutions that both defined health as a fundamental social right and envisaged the construction of models based on universal public health care. We can also mention Cuba, which implemented a public and free system in the early 1960s following the institution of the socialist regime. Nevertheless, the landscape of health policies and systems in peripheral countries, including in Latin

America, remains characterized by segmented systems, where several subsystems coexist and are responsible for the care of different population groups. Individuals are subject to distinct rules for financing, affiliation, access, and service network, determined by income levels and occupational status (Lobato and Giovanella, 2012). Even though similar challenges can be observed in wealthy countries, these inequalities seem to be more pronounced in the periphery.

The conditions under which peripheral countries operate contribute to explaining the challenges they face to consolidate national PHS. In central economies, the expansion of public systems and the associated increase in social expenditures in the post-war period coexisted with high levels of employment, economic growth, and financial stability. Amidst processes of "catching up", other countries sought to replicate these institutions under profoundly different circumstances. Taking Latin America as an example, the region was (and continues to be) characterized by high degrees of labor market informality, economic volatility, and political instability. Moreover, these countries attempted to create or expand public systems already in the neoliberal period, which, as we will see, imposes major barriers to approve substantial increases in public health spending and provision. Unsurprisingly, the systems in the region have never been able to achieve the standards of services and levels of redistribution of their European counterparts (Fleury, 2017; Lavinas, 2013; Lavinas and Simões, 2015; Vuolo, 2012).

PHS in both central and peripheral countries entered a new phase in the 1980s with the advent of neoliberalism. Similar to the shifts that led to the creation of the first systems in the post-war period, the structural reforms imposed on them from this moment on can be associated with both material and ideological transformations in the global capitalist system. Several factors contributed to the presumed need to carry out structural reforms in PHS by the late 20th century, including public budget crises, the arrival of right-wing governments to power, and the emergence of a new economic policy paradigm underpinned by a different approach towards public revenues and spending (André and Hermann, 2009; Böhm, 2017; Yilmaz, 2017, Fine and Saad-Filho, 2017).

Since the late 1970s, public budget deficits have been serving as the main justification for carrying out reforms in PHS. While the dominant discourse explains these deficits primarily as a result of growing public health spending, the slowdown in government revenues is an equally if not more significant factor in explaining the deterioration in government accounts. Revenue collection was increasingly constrained by factors such as slower economic growth, rising unemployment, tax cuts on private profits, and the erosion of tax bases due to the internationalization of production and capital flows. At the same time, governments were less willing to tax private and notably financial capital, creating room for vast amounts of poorly taxed income and wealth (Hermann, 2010; Huffschmid, 2009; Sell, 2019; Streeck, 2013).

Along with the slowdown of revenue collection, public expenditures were on the rise, notably in health care. This was largely due to costs in the sector tending to naturally increase over time accompanying positive developments such as longer life expectancies, the incorporation of technology and medical discoveries in health care services, and population

growth (André et al., 2015; Böhm, 2017; Yilmaz, 2017).[44] The resulting increase in health spending eventually clashed with the slowdown of revenues, leading to budget constraints. This fed a discourse of spiraling costs that needed to be put under control (André and Hermann, 2009). As noted by Moran (2000), no policy area of social provision has been more dominated by the search for cost containment since the end of the long boom than health care.

Ideological and political factors also played an important role in driving reforms in PHS. In several countries, the financial challenges faced by PHS paired with the rise of neo-conservative parties to power (André and Hermann, 2009; Hermann, 2010). These governments upheld a neoliberal agenda which aimed at "rolling back the State", downscaling public provision in favor of private initiative and private capital (Fine, 1999). It is important to emphasize that the neoliberal agenda not only resisted the expansion of public provision but also contributed to the financial hardship faced by public systems, not least due to the greater resistance to taxing capital mentioned above. This new era in politics influenced the possibilities of passing reforms in PHS, the forms of implementing them, and their content (Yilmaz, 2017). It determined the direction of the reforms that followed suit; the prevailing idea was that public deficits should be reduced, including in health, and controlling expenditures was the primary means for doing so (Agartan, 2012; André and Hermann, 2009; Hermann, 2010).

Neoliberal reforms did not necessarily reduce the importance of PHS but did lead to substantial changes in how these systems work. In countries with consolidated systems, governments imposed spending limits to reduce budget deficits, restricting the expansion of public provision and coverage. Other "adjustment measures" typical of the neoliberal period included caps on hospital budgets, the rationalization of costs in public facilities, the introduction of co-payments and performance indicators, wage cuts for medical staff, and the outsourcing of services to private providers, to mention a few (André et al., 2015; Hassenteufel and Palier, 2007; Ortiz et al., 2015).

In the case of peripheral countries, one distinctive trait of their experiences was that the pressures against the expansion of public spending and services fell upon systems that were already much more fragile. Another trait was the role of foreign players in pressuring for reforms and shaping how they would play out. Foreign actors gained considerable influence in shaping public policy in the context of the debt restructuring processes following the foreign debt crises that ravaged peripheral countries in the 1980s. Central to this influence was the so-called "Washington Consensus" – a set of policy recommendations promoted by the United States government, multilateral organizations (namely the IMF and the World Bank), and international creditors as the "standard" reform package for crisis-wracked countries. Reflecting the neoliberal ideology, the "structural adjustment policies" informed by the Washington Consensus combined measures for liberalization, privatization, deregulation, and budget austerity, among others (Bayliss et al., 2016a; Fine and Hall, 2012). These measures were touted as necessary to restore the "fiscal soundness" of indebted

[44] In the context of the pharmaceutical industry, price manipulation from pharmaceutical companies has been another crucial factor to explain rising costs (Abecassis and Coutinet, 2017; Lazonick et al., 2017).

economies and their capacity to repay their obligations. International institutions, namely the IMF and the World Bank, attached such recommendations as loan conditionalities in lending agreements to enforce them (Ruckert et al., 2015).

Up to this moment, most health care policies carried in the so-called "emerging countries" aimed at extending the scope of services and facilitating access to them. Especially from the 1990s onward, this was somehow hindered due to the conditionalities imposed by structural adjustment programs (Ruckert et al., 2015; Yilmaz, 2017). Following the pressures of the international community, governments across Latin America, Africa, and Asia limited public health expenditures and promoted pro-market reforms (Bayliss and Fine, 2008; Dao and Nichter, 2016). These reforms took highly different forms in each country, but studies often mention fiscal austerity, service cutbacks, the introduction of user fees, selective insurance packages, and other measures that increased the burden of health care financing borne by individuals and the private sector (Dao and Nichter, 2016; Ruckert et al., 2015; Yilmaz, 2017). This policy paradigm hindered public investments in peripheral countries, preserving their historical legacy of segmented and exclusionary health systems (Giovanella and Faria, 2015).

Ruckert et al. (2015) highlight a crucial mechanism through which the Washington Consensus guidelines and the related shifts in health policies in peripheral countries connect to the process of financialization that has been taking over the global economy since then. The authors argue that the pressures made by international financial institutions (IFIs) and the global creditors behind them on these governments aimed at saving resources so they could serve their foreign debts. A crucial way to save funds was by restraining public spending, including in health. As explained by the authors,

> Given globally integrated financial markets (another outcome of neoliberal economics), governments require the confidence of the IFIs to fund their operations through sovereign debt markets. Financial markets generally remain closed to governments lacking IMF support, fiscally coercing them to remain on track with IMF lending agreements and to follow IMF policy advice. Loss of policy space [the freedom, scope, and mechanisms that governments possess to choose, design, and implement public policies] includes a wide range of policy areas, but in our subsequent discussion we focus on pathways directly related to health care (…) **The influence of structural adjustment policies on national policies (…) resulted in resources being diverted away from health care due to IFIs pressure to pay off debts first.** (…) At times, even development aid for health has been found to be diverted by developing countries to the repayment of national debts" (p. 41-2, emphasis added).[45]

Since the turn of the century, evidence of the negative impacts of structural adjustment policies on people's lives has led to growing criticism of the Washington Consensus. This gave rise to the so-called "Post-Washington Consensus", an apparent rethinking of the standard policy framework prescribed to peripheral countries (Bayliss and

[45] Moreover, it can be argued that the very own processes of privatization (meaning the downsizing of the public and the strengthening of private provision, such as those fomented in this period) serve to the interests of financial capital (see section 2.4).

Fine, 2008; Fine and Hall, 2012; Ruckert et al., 2015). At the surface, the revised policy approach seemed to distance itself from the previous paradigm by adopting a more favorable position regarding State intervention and less radical measures to promote private markets. It acknowledged space for governments to address market imperfections and adverse distributional effects from privatization through piecemeal interventions. Yet, in practice, the policies carried out under the new "consensus" seemed to depart very little from the previous one. In many cases, it added further conditionalities that favored free trade, privatization, deregulation, and fiscal austerity – only this time with a more explicit call for governments to address their failures.

More recently, a new vision of "universality" started taking over the health policy agenda for peripheral countries. Since the early 2000s, the policy recommendations for these countries seemed to incorporate ideas of "health for all", but in a much different way than that applied by wealthy countries in the previous century (Dao and Nichter, 2016). The blueprint of public health policies for middle- and low-income countries today is based on the "Universal Health Coverage" (UHC) approach (WHO, 2005), championed by the World Health Organization with the support of other multilateral institutions. Since 2010, the WHO and the World Bank have provided technical assistance to more than one hundred countries so they could implement the UHC framework (WHO, 2015). The approach also became one of the core recommendations for countries to meet the health-related targets of the *Sustainable Development Goals*, established by the United Nations and signed by 193 member states in 2015.

The idea of universality adopted in our work resonates with the classic idea of *universal care*, and should not be confused with today's much-heralded concept of *universal coverage* that informs this policy proposal. Although a minor difference in name, there is a large difference in meaning. The former stands for equal access to services at all levels of care. By analyzing the UHC framework, one could argue that it does not propose a new form of achieving universal health care, but rather a reinterpretation of the concept. The programs for universal coverage entail a far more limited scope in terms of the services guaranteed by the government compared to the systems created in the previous century informed by the idea of universal care (Global Health Watch, 2014; Sengupta, 2013; Stuckler et al., 2010). In particular, the UHC framework prescribes a central role for the State in securing funding (Dentico, 2019), but does not specify which services should be covered and who should benefit from them. The focus of government action is on subsidizing demand to avoid individuals facing significant financial hardship when dealing with health risks. Public funding is usually steered toward guaranteeing primary care and supporting access to more complex services by helping to pay for private services and insurance (Giovanella et al., 2018). In this way, access to all levels of health care is only possible with a high participation of the private sector. This model of health care financing often calls for "affordable" user fees, (possibly subsidized) health insurance, private services, and the expansion of privately owned health care infrastructure so one can access all levels of care (Hunter and Murray, 2019).

That public coverage may not guarantee a sufficient breadth of care services, including for the poorest groups, is an important consideration that is often overlooked

(Stuckler et al., 2010). The right to public health in peripheral countries through an array of promotive, preventive, primary, and curative services becomes displaced by a much more restricted right to health care "coverage" for basic services provided by public or private entities. This means replacing the policy goal of building a national health system (as an integrated network of standard, socially acceptable pattern of services at all levels of care) and replacing it with an approach in which public provision equalizes only at the level of basic care services, leaving the rest tailored according to purchasing powers (Dentico, 2019).

In retrospect, the evolution of public health policies and PHS across central and peripheral countries over the past century describes two fundamental and apparently contradictory trends. On the one hand, there were universalizing measures seeking to expand access and allow individuals previously excluded from the public system to be included and cared for (Abecassis et al., 2017; Barbier and Théret, 2009; Batifoulier, 2015). In some countries with PHS, including wealthy ones, the laws to enforce universal health care did not come until the late 20th century.[46] On the other hand, neoliberal reforms restricted public health funding and supply. These seemingly paradoxical trends of expansion and retrenchment make sense in the neoliberal era once we recognize that "*neoliberalism has never, in practice, been about withdrawal or minimizing the State's economic role. On the contrary, neoliberalism has concerned State intervention to promote private capital*" (Fine and Hall, 2012, p. 53). Neoliberal reforms in PHS were one way to do that. Without dismantling public health policies and systems, they transformed the latter into venues for the expansion of private capital and the private appropriation of public funds.

Reinforcing the argument that PHS reforms have a particular role in the neoliberal period, it is interesting to note that these reforms have been implemented continuously regardless of the prevailing political spectrum. Right-wing governments were the main advocates and often introduced the first reforms, and therefore tend to be seen as mainly responsible for these shifts. However, right-leaning governments did not come into power at the same time across western countries, and there was usually an alternation of parties over time. This did not prevent the continuation of reforms, which have been embraced and often expanded further by center- and left-wing administrations. That the process of PHS reforms is an enduring process that has been underway for at least four decades, led by policymakers of different political stances, suggests that they should not be understood as simply an agenda of right-wing politics. It seems much more reasonable to interpret those changes as part of the broader economic and social restructuring that underpins the expansion of "*globalized financial capitalism*" (Fine and Saad-Filho, 2017, p. 698), a process that goes far beyond individual political wills.

Although the process of neoliberal reforms in PHS has been going on for decades, we argue that the mechanisms through which these served private capital have evolved since the beginning of the neoliberal period. This is our object of discussion in the two following sections.

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[46] This is the case of France, for example, which approved universal insurance coverage in 1999 (chapter 3).

2.2. The conventional conceptual framework on health systems change

Neoliberal reforms have resulted in non-linear processes of transformations in PHS. They did not necessarily reduce public health spending, but certainly altered the nature of expenditures, the conditions of access to benefits, and the involvement of the private sector. In light of the process of financialization and its inroads into sectors of social provision, these reforms are likely to be increasingly tied to financial capital. To argue that financialization should be integrated into the conceptual framework used to assess PHS reforms, we can start by outlining the concepts commonly used to examine the latter and the policy shifts they refer to. This can help to see more clearly the extent to which some events may not fit perfectly into usual concepts and require the introduction of new ones, such as financialization, to better explain them.

2.2.1. Common terms to assess PHS reforms

Rather than a single movement, the process of neoliberal reforms is a mosaic of policy shifts implemented in varying ways and degrees in each country. This diversity of international experiences led to an extensive body of research dedicated to studying the evolution of health systems since the 1990s, which we refer to as the literature on *health systems change*. This literature employed a varied array of concepts to grasp the specificities of each type of reform in PHS. Some terms are used with greater frequency to describe these reforms, including *economization*, *marketization*, *privatization*, *commercialization*, and *commodification.*[47] They constitute what we will call the "conventional" conceptual framework of PHS research. The exact definitions of these concepts vary from author to author, and there is debate as to where their respective boundaries lie (Mercille and Murphy, 2017). Although differences of opinion exist, there is some agreement on the general meaning associated with each one.

The process of economization describes changes at the level of ideas and methods. It refers to the extension of economic logic, practices, and calculation into new areas (Çalışkan and Callon, 2009; Dempsey, 2017). In the public sector, economization has manifested in the introduction of languages, principles, and metrics from the private sector (notably non-financial companies), aiming at promoting better governance and more efficient distribution and application of limited resources (Ewert, 2009; Yilmaz, 2017). The adoption of doctrines from the so-called "New Public Management" approach is the most glaring example of this process. This denotes a novel approach for public management developed in the 1990s that called for the incorporation of managerial and organization techniques from the private sector to enhance performance and decrease costs (Mercille and Murphy, 2017; Simonet, 2011; Yilmaz, 2017). In health care, economization processes can be observed when the public bodies responsible for health systems start framing the latter issues in terms of monetary costs and benefits, adopt cost-benefit analyses, introduce

[47] This should not be seen as an exhaustive list; other terms have also been used to assess reforms, although their use appear to be less common or circumscribed to specific countries. This is the case, for example, with *corporatization* (Preker and Harding, 2003) and *liberalization* (Filippon et al., 2016).

expenditure and efficiency targets, and manage by metrics, to name a few.

The idea of marketization has been used to describe changes at the level of internal practices, which came largely as a consequence of this new approach toward public management previously mentioned. It denotes the process through which market structures are extended to new areas, creating possibilities and incentives for buying and selling where these did not exist before (Agartan, 2012; Dempsey, 2017; Whitfield, 2006). In the public sector, marketization reforms reorganize exchanges in the public system to simulate conventional consumer markets. The underlying assumption is that operating in a competitive environment would create incentives for public bodies to decrease costs and increase efficiency (Ewert, 2009; Hermann and Verhoest, 2012; Yilmaz, 2017). In national health service models, the chief example of marketization reforms is the creation of "internal markets", with the government splitting public bodies into purchases and providers of services and placing them in competition with one another (and sometimes also with private actors) for the best deals. In social insurance systems, an evident form of marketization is the introduction of competition between different insurance funds to attract beneficiaries (André et al., 2015; Bayliss, 2016; Hermann, 2010).

The concept of privatization is the most widespread term in the literature on health systems change and can encompass several types of reforms in PHS. It is frequently employed as an "umbrella term" to encompass the measures described above, in addition to any public sector restructuring that leads to greater participation of private actors within public structures. The strict definition of privatization refers to the total transfer of ownership from public to private entities (Savas, 2000). But this definition has little applicability in health, where such experiences have been rare (André et al., 2015). When applied to the public sector, the term privatization usually appears with a fluid meaning to denote any transfer of responsibilities and activities from the public to the private sector (Hansen and Lindholst, 2016). A more appropriate definition for privatization, in the context of health systems change, is the delegation or partial transfer of public management, ownership, financing, or provision of public health activities to private actors (Mercille and Murphy, 2017; Starr, 1988).

Privatization, as defined above, can appear in many ways. Shifts in management, for example, can be seen in the adoption of a private management *rationale* by public actors, which coincides to a large extent with the ideas of economization and marketization previously described. But privatization reforms also include more tangible shifts in the dimensions of ownership, financing, and provision. Changes associated with these forms of privatization may involve, most often, the externalization of services and costs from public to private actors. Some of the most common measures described by classic works on privatization in national health service systems include the outsourcing of public provision to private providers and the authorization of private practice in public facilities. In social insurance models, privatization tends to be associated with the introduction of co-payments, the reduction of the scale or scope of public coverage, and incentives to contract voluntary health insurance. In both cases, these reforms often result from the imposition of measures on the public health budget, such as the establishment of rules for public health expenditure growth and the capping of hospital budgets (Abecassis and Coutinet, 2021; André et al.,

2015; Mercille and Murphy, 2017; Starr, 1988).

The concept of privatization allowed the literature on health systems change to draw attention to the fact that PHS may witness significant shifts while the overarching structure remains formally governed by the State or a public body. There are also terminologies to distinguish the shifts described above from processes of full divestiture (where public ownership is entirely transferred to the private sector). For example, Starr (1988) differentiates processes of "partial" and "total" privatization; Savas (2000) opposes "passive" against "conventional" privatization; André et al. (2015) differentiates processes of "internal" and "external" privatization. What these ideas have in common is that, in the first case (partial, passive, or internal privatization), they denote policy shifts that increase the participation of principles and actors originally foreign from the public sector while the system remains public.

As in the case of privatization, the concept of commercialization has been used to examine, within a single framework, several simultaneous and interconnected processes. In the case of health systems, it suggests the use of market relations and the expansion of for-profit activities across the public and private health sectors. A particularly well-known work on the topic associates "commercialized" health care with three main developments: the provision of health care services through market relationships to those able to pay; the investment in, and production of, those services for cash income or profit; and health care finance derived from individual payment and private insurance (Mackintosh and Koivusalo, 2005).

To conclude, commodification is the underlying change that underpins the developments described in this section. Commodities are defined as goods that can be valued according to their material properties and can be priced, bought, and sold in markets (McDonald and Ruiters, 2006; Oliver and Robison, 2017). Commodification refers to the process of attributing the meaning and features of a commodity to something previously not considered as such. The commodification of health qualitatively reconstitutes it in such a way that it starts being seen as a commodity (Vaittinen et al., 2018). It strips health-related activities of their image as special activities with intrinsic value that societies should organize for providing collectively. In doing so, health goods and services can be priced, exchanged, and generate privately appropriated gains (Agartan, 2012; Swyngedouw et al., 2002).

2.2.2. Conventional understandings of PHS reforms: deconstructing the notion of privatization

Privatization is arguably the most well-known concept to describe reforms in PHS change. Therefore, it can be used as a reference point to explore in greater depth how these reforms have been generally interpreted in the literature. We can explore the context in which privatization reforms emerged, their justifications, characteristics, and impacts on public systems. This will help us to make the case, later on, that privatization and financialization

are different (although related) processes.

Agents

The easiest way to understand the differences between privatization and financialization is to consider the agents involved in the policy shifts. When the concept of privatization first became popular in health systems research, the importance of distinguishing the type of private actors most directly involved in these changes was not immediately clear. However, the present moment gives us the privilege of hindsight. It can be argued that the developments associated with privatization described above refer, most often, to measures that increased the participation of private non-financial actors in health financing and provision, either directly or indirectly. But the so-called "private sector" also encompasses financial actors, a distinct set of entities. In Box 2.1, we explicitly highlight the features of non-financial companies and differentiate them from financial companies, a distinction that is instrumental in our upcoming argumentation.

Box 2.1. Deconstructing the "private" sector:
financial and non-financial companies

National accounting systems (IMF, 2017; UN, 2009) distinguish three types of entities that perform economic activities in the private sector: financial corporations, non-financial corporations, and non-profit institutions.

Financial corporations are mainly focused in providing financial services – activities related to the supply, intermediation, and management of funds and investments for other entities. They receive income from performing these activities, which comes in the form of interest payments, dividends, capital gains, and fees. Private financial actors include but are not limited to commercial banks, investment banks, investment funds, insurance companies, pension funds, and asset managers.

Non-financial corporations focus in producing, selling, and trading goods and non-financial services. The latter include any services that do not fit into the category of financial services. These corporations receive income from such activities in the form of business profits. These corporations include manufacturers, suppliers, and retailers, utility companies, and service providers, among others.

Non-profit institutions produce and distribute goods and non-financial services outside of the market logic. They provide most of their output either free or below market prices, and cannot provide profits, financial gains, or any other types of income to the units that control or manage them.

The term "corporation" is used in this context to designate "*all entities that are capable of generating a profit or other financial gains*" (UN, 2009, p. 66). This definition differs from its typical usage in the United States, associated with large-scale business owned by different shareholders. To avoid misunderstanding, throughout this work, we preferer using the term "companies", which includes several types of business (MacMillan Dictionary, 2021) and converges with the interpretation used in national accounting systems.

In general, notions of privatization employ the term "private" in a broad meaning to encompass different sets of private actors. The three main types of agents mentioned by studies of privatization reforms, especially in the 1980s and 1990s, are individuals, health service providers, and insurance funds (in the latter two cases, both for- and not-for-profit).[48] Therefore, it can be argued that the companies more directly involved in and benefiting from earlier rounds of privatization were *non-financial companies*, whose main activity was the production and commercialization of health goods and services. These include, for example, private hospitals, clinics, care facilities, and providers of medical goods. For the purposes of this work, we will refer to these agents as private health companies, in contrast to financial companies.

In several western countries, the private health sector until the late 20th century described a scenario where a significant part of health companies operated under traditional ownership structures, belonging to families or individuals with a professional record in the sector. The primary sources of income for these companies came from activities related to health care goods and service provision. Their expansion was largely dependent on expanding the capacity to produce drugs, equipment, and services, as well as the incremental demand for them. They presented relatively low levels of leveraging and weaker (if any) ties with financial institutions and investors. There are many ways in which these companies benefit from privatization reforms. Budget cuts or restrictions in health care coverage, for example, increase private health spending, boosting demand for privately provided services. Outsourcing and other measures that increase public health spending with private suppliers have a similar effect.

Along with private service providers, another important segment mentioned in the privatization debate comprises insurance funds. Technically, insurance funds fall into the category of financial companies. Still, the funds described in the earlier literature on health systems change operated in a much different context.[49] In comparison to today, health insurance companies were larger in number, smaller in size, and a higher share of them was specialized in health and related services. A significant part of these companies had autonomous ownership structures, independent from larger financial corporations. Also, there was a greater market share occupied by non-profit institutions. Their expansion depended on increasing the number of beneficiaries and the value of premiums.

Narratives

The narrative created around PHS in the neoliberal period, which contributed to justifying privatization reforms, described these systems as overspending and inefficient (André and Hermann, 2009; Bayliss, 2016; Frangakis and Huffschmid, 2009; Maarse, 2006). Advocates of privatization argued that, one, costs in public health care were "out of control",

[48] The systematization of the main agents involved in the reforms and the typical traits of the health sector described in the present and following sections were elaborated by the author based on a compilation of theoretical and empirical studies for advanced and emerging economies. The full list of references can be found in Annex 1.
[49] For the sake of simplification, we include non-profit institutions in our notion of non-financial companies, once they provide goods and non-financial services rather than financial services.

and there was a need to reign them in; and two, that the health care system was inequitable or ineffective, failing to deliver appropriate care (Stuckler et al., 2010). Accordingly, the main justifications presented for introducing private practices, actors, and the logic of competition in the 1980s and 1990s was that this would allow reducing costs and increasing efficiency in the public system. Besides lower costs and greater "value for money", other arguments in favor of privatization included improving the quality of the services and enhancing consumer choice (André and Hermann, 2009; Fine and Bayliss, 2016; Frangakis and Huffschmid, 2009; Maarse, 2006; Whitfield, 2015).

Theoretical underpinnings

The theoretical underpinnings of privatization derive from different strands of neoclassical economic theory. The belief that private initiative is always cheaper and more efficient than the public sector derived from a combination of ideas borrowed from different theories such as the theory of property rights, the theory of the firm, the theory of industrial organization, and the theory of transaction costs. Following different paths, such theories suggest that profit motive, competition, and ownership rights always lead to the most efficient outcomes (Fine, 2008; Loxley and Hajer, 2019; Maarse, 2006; McDonald and Ruiters, 2006; Starr, 1988). This leads to the conclusion that private firms can optimize resource allocation, provide better-quality services to more people, and charge more competitive prices than the public sector (Mckinley, 2008). Another important reference is the theory of public choice, which contends that public provision is inherently prone to inefficiency and corruption (Fine, 1999; Starr, 1988). Fine (2008) draws attention to what he describes as the "*shaky*" theoretical foundations of privatization; as this diversity of underlying theories suggests, the *rationale* in favor of privatization seems to have been built by combining ideas from different theories, selected arbitrarily and in the most convenient way to justify the reforms.

Fine (*op. cit.*) also reminds that the neoliberal argument of "State failure and private success" informed by these theories is reinforced by the often neglected fact that the public sector tends to concentrate its efforts on essential and less profitable activities. According to the author,

> A longer view of the choice between public and private provision, stretching back into the nineteenth century, reveals that the private sector presses to provide when and where it is profitable for it to do so (and to use the State to make it so) and, equally, does not embark upon, or abandons, provision where profitability fails. In contrast, the State is saddled with the burden of provision irrespective of commercial viability and can be pressured to support private at the expense of public provision. (…) The public sector tends to become the provider of last resort as opposed to the private or privatized sector that can cream off the more commercially viable and readily served markets. (p. 15, 24).[50]

[50] For descriptions on how the State tends to cover the "hard to serve" across different segments of public activities and health care, see also Bayliss (2002), Bayliss et al. (2016b), Sestelo (2017a), and Tansey et al. (2021).

Impacts

The impacts of privatization on PHS are highly debated. Scholars have critically observed that public sector reforms continued despite the absence of systematic evaluations demonstrating superior outcomes for the population or public finances (Bayliss, 2002; Fine, 2008; Whitfield, 2015). As acknowledged by the United Nations (UN, 2018), human rights standards are systematically absent from privatization agreements and evaluation processes. As stated by the then Secretary-General of the institution, "*it is clear both from the evidence that exists and from the basic assumptions underpinning privatization that it negatively affects the lives and rights of people"*; still, "*few detailed studies have been undertaken and that relevant data are often not collected"* (p. 24).

Since the early 1990s, scholars have consistently shown that privatization measures contributed to deterioration in the quantity and quality of public provision and coverage in PHS as well as the working conditions of the professionals working for the system. Another observed effect was the increase in the costs borne by individuals, directly or through private insurance. As a consequence, privatization is also associated with greater inequalities in access to health care and the increase in total health spending (André et al., 2015; Böhm, 2017; Hassenteufel and Palier, 2007; Hermann, 2010; Laurell, 2016; Maarse, 2006; Ortiz et al., 2015).

Taking stock, our review suggests that the usual concepts employed to describe neoliberal reforms in PHS have been developed with a view on private health companies, at a time when the financialization process was not as pervasive and evident as it is today. The notion of private actors used here put little emphasis on financial players and how they might have been involved in PHS reforms. These include, for example, banks, investment funds, and individual investors. However, there is reason to think that these agents are having an increasingly important role in the health sector at large and PHS in particular. In the following section, we turn to the literature on financialization in health care to understand how these actors have been influencing developments in the sector. We also discuss how scholars on health systems change have been framing their influence on public systems.

2.3. Financialization in the health sector

In recent years, a number of scholars have remarked that current developments in the health sector are qualitatively and quantitatively different from those established by seminal health policy studies (Bayliss et al., 2017; Sestelo, 2017a). Especially since the turn of the century, the involvement of financial actors with health activities became more intense, diversified, and spread across the private for-profit, non-profit, and public spheres. In this process, financial institutions and the infrastructures of financial intermediation have come to play a central role in the health domain (Dentico, 2019). This suggests that the nature of part of reforms in the public sector is likely to be different from those described in the previous section. This is corroborated by Lavinas and Gentil (2018), who note that "*the topic of privatization alone is no longer sufficient to explain this process of transferring responsibilities, previously in the hands of the State, to profit-oriented companies*" (p. 12). Also, Hunter and Murray (2019) describe health financialization as "*the latest emerging*

phase of health system change" (p. 2), representing "*a new phase of capital formation that builds on, but is distinct from, previous rounds of privatization*" (p. 8).

This is not to say that the classic literature on health systems change has been oblivious to the growth of financial investments and actors in health care. Still in the early 2000s, authors were calling attention to the entrance of multinational corporations of finance capital into the health insurance and service sectors, and their efforts to come closer to state institutions and social security funds (Iriart et al., 2001; Maarse, 2006; see also Hermann, 2010). Yet, the extent of such events was considered still limited in scale and scope at this point. Maarse (*op. cit.*), for example, observes that "*the role of private investors [in health care investments] has always been limited. Some countries are now witnessing the emergence of private investors in health care*", but these are described as a "*still small-scale phenomenon*" (p. 995).

Some works mention the resort to financial capital by public entities as a particular type of privatization. This is far from being the focus of analysis; as we have seen, privatization measures were generally associated with policy shifts seeking to diminish expenditures in the public system, passing them onto private actors (both individuals and companies).[51] Still, some authors mention policy shifts seeking to increase revenues for the public system, raised from private actors, and describe them as a specific form of privatization in the dimension of financing or investments (e.g., André et al., 2015; Mercille and Murphy, 2017; Pollock et al., 2002; Whitfield, 2006). Mercille and Murphy (*op. cit.*), for example, describe the privatization of investments as the process "*when funding sources of public assets and service providers become private, for instance by raising private capital instead of relying on public funding*" (p. 6). Nevertheless, the examples mentioned in these works are mostly limited to one specific instrument, PPPs, which use private investments to finance public infrastructure. The volume of PPP projects to build public hospitals has grown dramatically in the last decades.

For the reasons above, it is safe to say that the early debate on the resort to private finance by the public health sector was mostly limited to the case of infrastructure financing. Also, that the resort to financial capital is explained as a form of privatization makes it difficult to examine the specificities of such developments in relation to other processes included in the same category.

2.3.1. The state of the art of the literature on the financialization of health

Over the past decade, some scholars have been using the concept of financialization to investigate the particular ways in which financial actors, instruments, and interests are shaping changes in the health sector. The "financialization of health" is now a flourishing area of research (Hunter and Murray, 2019). This literature discusses the transformation of activities related to health financing and provision into financial assets, along with the related

[51] Maarse (2006), for example, measures privatization in health care financing "*in monetary terms as a shift from public to private spending or, more concretely, as a decrease in the public fraction in health care spending*" (p. 989).

increase in the participation of financial actors in the sector. It also calls attention to the incorporation of behaviors typical of financial companies by health actors, such as the quest for maximizing financial gains and market value. In general, these studies adopt a critical perspective on how these developments affect the conditions of access to health care by individuals.

Seddon and Currie (2017) describe the "financialization of health" as "*the exchange of goods and services as financial instruments*" (p. 1). Bayliss (2016) defines it as the "*transition from a public service to a financial asset*" (p. 4). Similarly, for Hunter and Murray (2019), health financialization means the process of "*transforming population ill-health into zones for investment and creating saleable commodities that can be traded by domestic and transnational private capital*" (p. 9). Paying attention to the actors behind such transformations, Vural (2017) contends that, in the health sector, the process of financialization "*can be observed by the greater reliance of health care providers on financial markets, as well as the increasing penetration of financial actors and institutions into health care provision and funding*" (p. 1). These transformations are extremely significant. As demonstrated by Bayliss (*op. cit.*), as a consequence, "*the provision of health is being transformed from a local community service to a segment of global investment portfolios of international private finance*" (p. 40).

But how can health be transformed into a financial asset? And through what channels do financial actors enter the sector? What we currently know about the financialization of health comes mostly from the evidence provided by studies looking at global health policies, private health activities, and specific segments of the public and non-profit sectors. We can point to three processes that have been particularly important in reshaping the landscape of health care across these domains and can help us to better characterize this phenomenon. They concern the creation of investment platforms, changes in ownership structures, and the deployment of financial innovations.

Investment platforms: a new approach to finance global health policies

First, finance is changing the approach to funding global health programs. These include, for example, initiatives to fight epidemics and pandemics, guarantee primary health care in middle and low-income regions, and achieve the health-related targets included in the Sustainable Development Goals. This changing approach to funding global health is evident in the emergence of *investment platforms* (Hunter and Murray, 2019), which offer a new way to collect the necessary resources to finance such actions. These platforms are becoming a central strategy to raise and centralize revenues for collective interventions, gradually replacing traditional forms of financing (Erikson, 2015; Hunter and Murray, *op. cit.*; Stein and Sridhar, 2018).

The notion of investment platforms encompasses a hybrid category of arrangements allowing actions to coordinate and gather funds from different public and private actors toward a common goal. This is usually done through an independent governance structure

(Tchiombiano, 2019).[52] The idea of combining funds through independent financial structures underpins, for example, the "Global Fund to Fight AIDS, Tuberculosis, and Malaria" (a joint initiative of governments and private agents to eradicate these diseases in over 100 countries), the "Pandemic Emergency Financing Facility" (a financing mechanism set up by the World Bank to help to contain pandemics), and the "International Finance Facility for Immunization" that funds the Global Alliance for Vaccines and Immunization (a multi-stakeholder partnership set up by the Bill and Melinda Gates Foundation) (Hunter and Murray, 2019; Stein and Sridhar, 2018).

Investment platforms are designed to attract private funds using multilateral and government funding as a way to entice investors who otherwise would not have participated. Governments may place public funds into these arrangements directly or by providing subsidies and guarantees. In any case, this serves to de-risk investments and ensure returns, thereby attracting and leveraging private capital (Jomo and Chowdhury, 2019). Among the actors that allocate money into these platforms, one can mention national governments, multilateral organizations (e.g., the World Bank and the World Health Organization), philanthropic institutions (e.g., the Bill and Melinda Gates Foundation, The Rockefeller Foundation), banks, investment funds, other forms of financial investors, industry representatives, non-profit organizations, and private companies (Dentico, 2019; Hunter and Murray, 2019; Stein and Sridhar, 2018; Tchiombiano, *op. cit.*).

In order to welcome private funds, these arrangements "*transform new sectors and regions into investor-friendly asset classes and de-risk opportunities for private investment in those asset classes*" (Hunter and Murray, 2019, p. 6).[53] How these asset classes will be created, as well as the form and degrees in which financial actors are involved in this process, vary from case to case. Despite presenting different configurations, these funding strategies are generally managed by financial experts and bring in money from diverse sources that include financial institutions and investors (Tchiombiano, 2019), sometimes through the creation of investment opportunities such as the issuance of financial securities. The sources of remuneration can include income from intermediation and administration fees, interest payments, tax engineering, and monetary compensation for upfront investments, among others.

Critical scholars call attention to the fact that the volume of funds allocated to these platforms has been on the rise at the same time that traditional forms of humanitarian aid have been following a steep decline (Dentico, 2019; Hunter and Murray, 2019). In light of these trends, they suggest that financial investors and global philanthropic foundations (the latter closely related to financial and non-financial private companies) are "*leading the way in the transition of global public health funding models to private financial models featuring shareholder return on investment*" (Erikson, 2015, p. 4). Dentico (*op. cit.*) claims that the

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[52] Even if implicitly, the idea is heavily grounded on the logic of "blended finance", a term that has been recently applied to describe a new approach to development financing in middle- and low-income countries (UN, 2018). As the name suggests, the idea behind blended finance to is "blend" funds – that is, to pool money from different agents – in order to finance a specific project.

[53] Asset classes can be defined as forms of investment that exhibit similar characteristics, tend to behave similarly, and are subject to the same regulations (Lustig, 2014).

financialization of global health entails a redefinition of how the universal right to health is being interpreted and pursued, once decisions concerning population health become subjected to the imperatives of maximizing returns on investments.

Ownership restructuring: reshaping the landscape of private health

Private health care services and insurance are also undergoing major changes due to the expansion of the financial sector. On the one hand, health companies are increasingly relying on debt and financial markets; on the other, financial firms and investors are gaining ever more control over them. These developments occur mainly through processes of *ownership restructuring*, which allow financial firms and investors to expand their participation and influence in health care by acquiring rights over health services and insurance companies. This restructuring often occurs as a result of strategies carried out by health companies to attract investments and raise additional funds. Three examples of ownership restructuring processes particularly important in the health sector are (i) the issuance of securities by health companies (following processes of opening capital in stock markets), (ii) mergers and acquisitions, known as "M&As" (increasingly driven and funded by financial companies), and (iii) the increase in investments via investment funds (with private equity funds being a particularly important actor investing in health companies) (Vural, 2017).[54]

As a result of ownership restructuring processes, health companies end up listed in financial markets, are integrated within global financial corporations becoming part of a diversified portfolio of investments, acquire ownership stakes in other companies via open market operations, and take over other companies in closed transactions leveraged by private capital and intermediated by financial corporations (Lavinas and Gentil, 2018; Sestelo, 2018; Vural, 2017). There is extensive empirical literature describing how such processes reach for- and not-for-profit actors in both central and peripheral economies, including health insurers (Abecassis et al., 2018; Abecassis and Coutinet, 2021; Bahia et al., 2016; Martins et al., 2021; Mulligan, 2016; Sestelo, 2017a, 2018), hospitals and other care providers (Alles, 2018; Angeli and Maarse, 2012; Appelbaum and Batt, 2020; Horton, 2017; Lavinas and Gentil, 2018; Vural, 2017), and pharmaceutical companies (Abecassis and Coutinet, 2018; Klinge et al., 2020; Lazonick et al., 2017; Montalban, 2011).[55]

Although the intensity of these events varies greatly across countries and segments, together they determine a large part of current developments in the health sector. The case of private equity investments, a trillion-dollar industry, is particularly illustrative of the

[54] Securities issuance refers to the offering of stocks and bonds by health companies to investors in exchange for funds. M&As describe operations in which two companies merge to create a larger one, or when one company purchases another. Private equity is a form of investment in which specialized investment funds raise and centralize money to purchase, restructure, and sell a company for an expected profit. Public-private partnerships are long-term contracts in which the private sector assumes total or part of the financing, building, and/or operation of public projects. PPP projects can be financed by investment firms and banks, and ownership stakes can generate other assets traded in secondary markets.

[55] The discussion of this chapter is based on studies focused on health service provision and insurance. Although the discussion can be extended to the pharmaceutical sector, we do not deal with it directly, as the developments in this sector are highly specific and demand a separate analysis.

relevance of health care activities for the financial sector. Undertakings geared toward health companies are known for being some of the most profitable in the private equity world. Bain & Company (2019), a major firm in the field, examined investments across different sectors from 2009 to 2015 to find that health care deals have returned US$2.2 for every US$1 of invested capital, more than in technology, financial services, consumer infrastructure, and other common targets of private equity firms.

Financial innovations: a rising strategy for public and non-profit agencies

Financial innovations are another important movement pushing for the financialization of health. They occur through the creation of new asset classes to finance health activities. From the plethora of financial innovations appearing each day, we highlight the deployment of "health bonds", in which we include financial contracts and securities created to finance a specific health-related intervention. These bonds reflect the logic of "impact investing", a new approach to finance interventions that seeks to combine investments in activities that can promote positive social or environmental outcomes with the possibility of reaping financial returns (Andreu, 2018; Golka, 2019). Impact investing is generally used to raise funds for a specific policy intervention specified in advance. By engaging in contracts or purchasing securities, financial investors provide the upfront finance for the intervention and are reimbursed (usually with additional compensations) depending on the observed outcomes.

Public entities and non-profit institutions have been particularly interested in attracting funds via such types of instruments. This is particularly the case of "Social Impact Bonds", such as the "Cameroon Cataract Performance Bond" and the "Israel Type II Diabetes Social Impact Bond" (Clarke et al., 2019; Hunter and Murray, 2019; Lavinas, 2018b). Organizations in charge of global health interventions are following a similar path. They have been key sponsors of health bonds to raise funds for collective health policies, including via the investing platforms described above. Two important examples of health bonds sponsored by these novel financing arrangements are the vaccine bonds issued in 2006 by the International Finance Facility for Immunization (which finances the Global Alliance for Vaccine Immunization), and the pandemic bonds issued in 2017 by the World Bank (more specifically the bank's Pandemic Emergency Financing Facility).

Pandemic bonds became particularly known due to the so-called "Ebola bonds". These instruments offered attractive compensations for investors willing to bet against the spread of the disease in African countries. As explained by Erikson (2015), the World Bank issued these bonds to raise funds that could supposedly aid countries in the event of an Ebola crisis. Investors would receive interest payments during the duration of the bonds, as long as there would be no outbreak of the disease in the countries specified in the contracts. As published by Bloomberg (2019), Ebola bonds attracted a large number of investors, offering annual returns of up to 11% − far above other assets of a similar kind. A US$95 million tranche of Ebola bonds due by mid-2020 paid investors more than US$1 million each month. Such instruments end up surrounded by large controversies. One of the main reasons was that investors were sometimes paid while African countries suffering from the spread of

Ebola could not cash in the funds. This was justified on the basis that these countries allegedly did not meet certain conditionalities. These included some morally questionable conditions, such as the need for a minimum number of deaths in the national territory before triggering insurance payments.

Notwithstanding the importance of financialization, it is important to recognize that this is not the only relatively new concept that can contribute to explaining transformations in the health sector. It is important to pay attention, for example, to processes converting not only health financing and provision, but also health data, into new spaces for profit-making activities. This trend underpins concepts such as datafication and digitization, and can help in understanding the recent entry of Big Tech firms into the sector (Prainsack, 2020; Sharon, 2020, 2018). Similar to what we discussed for the case of financial actors, these authors show that major consumer technology corporations that had little interest in health in the past, Google, Apple, Facebook, Amazon, Microsoft, and IBM, are now making important inroads into the health and biomedical sector. According to Sharon (2020), not only tech corporations are encroaching into ever new spheres of social life but *"the (legitimate) advantage these actors have accrued in the sphere of the production of digital goods provides them with (illegitimate) access to the spheres of health and medicine, and more worrisome, to the sphere of politics*" (p. 2).

2.3.2. Gaps in the existing research on the public sector

Different from global health and private activities, the impacts of financialization in the public health sector are much less investigated. This is particularly true in the case of PHS.

The usual view on the impacts of financialization on PHS focuses on external changes, particularly on how financialization promotes fiscal austerity and thereby restricts the volume of funding available for these systems. Summing up arguments presented in the previous chapter, one of the most important ways in which financialization would lead to austerity is through the growing power of financial capital to control government funding and thereby influence decisions on the public budget. On the one hand, these decisions would contribute to lowering the taxation on capital and thus limit the growth of public revenues. On the other, they would impose a hierarchy of priorities for public expenditures, with those of finance at the top. The results are spending cuts, notably in areas of social provision. They serve to limit public deficits and debts, proving the government's creditworthiness, and save resources to pay its creditors.

Another common association found in the literature is between austerity in PHS and the development of the private health sector, today highly financialized. The former would create incentives for the latter to the extent that restrictions in the coverage, quantity, and quality of public services would stimulate the demand for private services and insurance. Beyond PHS, the public sector more broadly would also have a role in developing private markets. In particular, governments would contribute to the financialization of health by changing regulations and providing incentives and guarantees for investors and financial companies involved in health care. Favorable regulations and policies could secure profits,

mitigate risks, and enhance the profitability of private investments in health care.

However valid, depicting PHS as a supporting apparatus for the expansion of a private-cum-financialized health sector offers an incomplete picture of developments in the field. From this perspective, PHS would have only a passive role in the process of health financialization. Given the increasing adoption of financial instruments and strategies by public sector bodies (section 1.3), there is reason to argue that these trends will also reach PHS. This means they would be taking part in the process of financialization of health in much more active ways than what has been usually acknowledged.

When it comes to internal changes, we have seen that the bulk of the existing research on the incorporation of financial capital by public bodies focuses on the infrastructure segment, more specifically on the resort to PPPs.[56] This is true for both the literature on privatization and financialization. There is a considerable body of works using this latter concept to draw well-deserved attention to the dramatic rise of such "partnerships" and its growing relevance for health infrastructure (e.g., Bayliss, 2016; Bayliss and Waeyenberge, 2017; Fine, 2020; Loxley and Hajer, 2019). These works examine in greater detail the various ways in which private capital may participate and profit from these projects, such as by providing upfront financing for the building of hospitals or purchasing and trading infrastructure assets.

Different from infrastructure, there is little published research on how financialization might be reshaping the forms in which public health bodies are financing and providing services to the population. This means, for example, how these bodies may be participating in financial markets, partnering with financial institutions, and directly contributing to financial accumulation.

In particular, there is a surprising scarcity of studies on health financialization where PHS are at the center of the analysis. The only exception so far seems to be Bayliss' (2016) case study for the English National Health Service (NHS), a State-funded public health system. In this seminal work, the author provides robust evidence of mechanisms through which "*financialization has evolved within, and impacted upon, the NHS*" (p. 2). The author identifies different channels connecting the system with global financial institutions and investors, two of which seem to be particularly important. The first are Private Finance Initiatives (PFIs), the national equivalent for PPPs. PFIs were introduced in the 1990s, but they gained popularity from the 2000s onward. They have become the primary form of financing the construction of NHS hospitals. PFI arrangements are highly leveraged by commercial banks and institutional investors, and their asset streams serve for the creation of assets traded in financial markets. They have proven to be costly for the NHS, but highly lucrative for the institutional investors involved in them.[57] Another important channel for financialization highlighted by the author was via the outsourcing of services to private providers. This is directly associated with "classic" privatization reforms in the NHS taking place since the 1990s, which have increased the participation of private health actors in

[56] This contrast between internal and external processes of financialization has been first discussed by Chiapello (2019, 2017), who distinguishes those developments in the context of public policies more generally.
[57] Estimates suggest that, over these three decades, NHS hospitals received £13 billion in investments, but will have to pay back around £80 billion by the end of the contracts (Thomas, 2019).

public service delivery. As several private health companies providing services for the NHS are now owned or backed up by private equity firms, investment funds, banks, and investors, outsourcing puts the system in much closer contact with global finance than is usually acknowledged. Moreover, an important part of NHS revenues ends up being channeled to these actors as a consequence of such shifts[58]

Bayliss et al. (2016a) deploy the UK case study to offer another important insight for research on financialization in public systems: the realization that it is precisely the public nature of these systems that makes it difficult to perceive the transformations brought about by financialization. In the NHS, as in other public systems, access to health care continues to be mostly free or highly subsidized at the point of delivery. This means that processes of financialization tend to be obscured from the daily life of the population, making it more difficult to perceive see the transformations that might be taking place due to this process (see also Bayliss and Fine, 2020).

To provide additional elements that can help us conceptualize the process of financialization in PHS, we can turn to other countries committed to public and universal provision seeking evidence that these systems are incorporating financial capital into their funding sources. Making up for the lack of scholarly studies on the topic, we compiled information from different sources of information including academic publications in related topics, private sector reports, and law studies. As a general rule, similar to the English case, the regulatory shifts laying the ground for the developments described below started in the 1990s and gained momentum from the 2000s onward.

In Italy, Messina (2010; Messina and Denaro, 2006) and Cusseddu (2011) explain how the Italian health service system (Servizio Sanitario Nationale − SSN) started resorting to securitization to pay service providers. Securitization is directly linked to financialization, considered the main practice that allowed the financial sector to reach its current scale and scope (Davis and Kim, 2015; Leyshon and Thrift, 2007). It consists of taking illiquid assets, such as long-term debts, and, through financial engineering, transforming them into securities that can be sold to other agents and traded in financial markets. This practice provides the creditor with immediate liquidity, "securing" its gains, while it renounces at least part of the future reimbursement. The holders of the securities, in turn, receive compensation based on the principal and interest payments of the underlying debt.

In the context of systematic delays in the SSN's payments to its suppliers and mounting debts to the latter, the agencies charged with running the public system began to securitize suppliers' debts in order to raise the funds needed to pay them. In practice, these agencies securitize the suppliers' "receivables" – their rights to future payments for the goods and services they provided for the public system. In one of the most common modalities of securitization, the health agencies assign the receivables to an external body (a "special purpose vehicle"), which issues bonds in the markets backed by the debt claims.[59]

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[58] The interdependence between the public system and the financial sector can be illustrated by the fact that the announcement of cuts in the NHS budget in 2018 led to a decline in the price of shares of the main private hospital group that provided services to the system (Financial Times, 2018).

[59] There are still other modalities, such as when the regional governments assume the responsibility for the operation (see Messina, 2010).

This operation provides the health agencies with income to pay the suppliers in the short run; in the future, the public sector does not transfer money to the suppliers (which have already been paid), but to the investors who bought the securities, with added interests. As explained by Cusseddu (2011), securitization serves the immediate interests of public entities, which need to honor payments so that suppliers are willing to serve the system, as well as the investors, who acquire safe and high-yield assets. However, the author also highlights that this practice consists in the exchange of one form of debt for another, at a higher cost in the long run. The assets created from the securitization of SSN providers' debts are often listed, rated by credit rating agencies, and publicly offered in the markets. Messina (2010) identifies similar strategies of financial engineering to monetize health care receivables in Spain, Portugal, and Greece, countries that also have a PHS.

In Canada, a country with a publicly funded health insurance system (Medicare), the government has been resorting to financial instruments to finance both hospital infrastructure and health policy interventions. This is evidenced by the studies of Ryan and Young (2018) and Loxley and Hajer (2019), who assess the spread of PPPs and social impacts bonds across several areas of the public sector in the country. Although these studies do not focus exclusively on the health sector, their findings show that this is one of the areas where these strategies have been growing most rapidly. The main channel for financialization in health seems to be the construction of public hospitals financed by PPPs. The data presented in these studies reveal that the majority of existing PPP projects in Canada are in the health sector, and this is now the predominant mode of infrastructure financing for public hospitals. The strategy to use social impacts bonds to finance interventions, in turn, is still in its early stages, but with significant potential for growth. One of the first bonds sponsored by the Canadian government, in 2016, aimed at financing a health-related policy. This was the "Community Hypertension Prevention Initiative", designed to tackle risk factors for high blood pressure.

Moving on to examples for peripheral countries, Kumar (2016) uses the concept of financialization to explain a shift in the State's approach toward public health care in India. Although the country does not have a universal, comprehensive public system as in the previous cases, the author uses the concept of financialization to describe a clear shift in the orientation of public health policies in the country since the late 2000s. The State moved away from public investments in the existing tax-based, public service provision system, and started promoting publicly-funded health insurance schemes for low-income individuals and informal workers. In this context, financialization is not associated with the adoption of specific instruments and strategies, but with a transition from the goal of achieving universal service provision to the use of public funds to subsidize access to care via private providers and financial markets, in this latter case notably through health insurance.[60]

Although exploratory, this exposition supports the hypothesis that private finance is making inroads into PHS. It presented examples of how systems in different countries have been directly or indirectly resorting to financial actors and instruments as a way to

[60] As the author shows, the creation of publicly-sponsored insurance programs targeting the poor, seeking to achieve "universality", has been informed by the WHO's Universal Health Coverage approach (section 2.1.4).

complement or replace traditional forms of public financing. Even if providing solid evidence of the influence of financialization in the recent path followed by public systems, these are single-case studies that reflect different theoretical and methodological standpoints. They are not always focused on the health sector, and in some cases do not explicitly work with the concept of financialization. The relevance of the topic and the current research gaps warrant further discussion on how we might conceptualize and examine the process of financialization in PHS.

2.4. Financialization as a distinctive type of PHS change

As a research object, PHS lie at the intersection of two domains where financialization studies are far more advanced, the public and health sectors. The literature on financialization in each of these domains has been examined in the previous and present chapters, respectively. Taking inspiration from these bodies of research, we can suggest that financialization in PHS can be characterized by the increasing participation of financial instruments and actors in these system's structures of financing and provision. This can be seen, for example, through the incorporation of instruments and strategies that allow financial actors to lend money to public bodies responsible for the public health system. It may also be seen in the growing influence of financial interests in decision-making processes relative to public health care, favoring financial accumulation.[61] The discussion from hereon emphasizes policy shifts in financing structures, the most evident and straightforward way through which the financial sector has been gaining ground in PHS. Changes in financing circuits can occur through any instrument and strategy that allows financial investors and institutions to finance bodies responsible for the public health system (simply pit, to provide and exchange money with them, such as through debt and investments).

The remaining question concerns why these developments should be considered a particular kind of PHS change. As previously observed, some authors have classified shifts in financing circuits that welcome private capital as a form of privatization in the dimension of financing. Moreover, these shifts are associated with a narrow set of instruments. Throughout the previous sections, we have seen that recent developments that are changing the financing of global, private, and public health activities rely on a variety of instruments and strategies that have received little attention in privatization studies. The same can be said about the actors behind such instruments and strategies. These instruments, strategies, and actors are directly linked to the financial sphere. This gives reason to argue that financialization constitutes a particular type of PHS reform that is related but not equal to classic forms of privatization.

Despite the recognition that privatization does not fully capture contemporary trends in the health sector and the evidence that several of them are better described through the idea of financialization, there have been few attempts to draw clear limits between these concepts. As Karwowski (2019) critically observes, researchers tend to "*draw only vague distinctions between financialization and the implementation of neoliberal policies,*

[61] See the methodology section for a more detailed discussion on the definition we devised for financialization in PHS and the indicators we have chosed to conduct our empirical investigation.

especially privatization" (p. 1007).

In the following paragraphs, we take inspiration from our reviews on the processes of privatization and financialization to delineate some of the boundaries between these processes when it comes to PHS. We do so by highlighting some of the most important features, differences, and relations between these sets of reforms.[62] We can revisit the categories explored above in the case of privatization – the agents, narratives, theoretical underpinnings, and impacts most typically associated with this process – and consider the extent to which processes related to financialization bring novelties in these realms. Without losing sight of the limits to generalization (there have been signs of financialization for several decades now, and privatization continues to prevail across the sector), systematizing the most salient features associated with each concept serves two purposes in the context of this study. First, it allows for a clearer understanding of what distinguishes financialization processes from other types of reforms. Second, it puts the process of financialization in PHS in historical perspective, showing how it relates to other processes dictating the evolution of PHS in the neoliberal period, especially privatization.

Agents

Part of policy shifts in PHS today aims at reaching not the providers of private health services and insurance, but of money. The most salient feature of financialization is thus that the private actors involved in these shifts are, to a great extent, financial rather than non-financial actors. Different from health companies, financial companies do not focus on health; their primary business concerns money and investments. This is different from the outsourcing of public services to the private sector or the externalization of costs onto individuals and health insurance funds (section 2.22.1 above).

To be clear, what characterizes financialization is not the presence of financial instruments and actors *per se*. Health insurance, for example, is a longstanding practice, and non-profit insurance funds have even been referred to as the "hidden public sector" due to their instrumental role in ensuring the right to health in some countries (Hood, 1986, cited by Maarse, 2006). It is the centrality that finance assumes today that distinguishes the present phase; financial companies are not simply mediating or backing up, but leading and benefitting the most from many policy shifts in the health sector at large and in public systems in particular.

Concerning the timing of this process, the evidence collected so far suggests that changes in the health sector and within PHS paving the way for the use of financial capital date back from the 1990s, but grew at a much faster pace from the 2000s onwards.

Interestingly, even when there is the incorporation of non-financial actors from the private sector into the public system, this has now the potential to expand the participation

[62] The features and relations between the concepts of privatization and financialization described in this section are systematized in Appendix 1. They result from a review of works from both the established research on health systems change (section 2.2) and the more recent literature on health financialization (section 2.3). The references are duly listed in the table.

and influence of financial agents within the public system. This is because the landscape of the private health sector is not the same as it was decades ago. Studies on how financialization has reshaped the landscape of private care providers and insurance companies (section 2.3.1) allow us to observe some differences between traditional business models that used to prevail in the past and new ownership structures that are becoming ever more common in the sector. Traditional ownership structures, with specialized health companies often owned by individuals or families with a professional record in the sector, are increasingly coexisting with companies controlled by global multi-sector financial firms. When health companies are sold to the latter, health provision enters a vast portfolio of other activities that these financial corporations invest in. Health care companies across the world have been integrated into the portfolio of firms that also invested in energy distribution companies, restaurant chains, music store chains, airports, credit card services, to name a few (e.g., Bayliss, 2016; Iriart et al., 2001). In several instances in which this has occurred, previous company owners were incorporated into the new financialized structures, being offered a seat on the board of directors and opportunities to become important shareholders, illustrating the extent to which previous ownership arrangements are being overrun by new ones.

In the case of insurance companies, these are now fewer in number and larger in size. Also, non-profit insurers specialized in health are losing space to for-profit insurers attached to banks or that constitute large financial institutions operating in multiple segments of the insurance industry (e.g., Abecassis and Coutinet, 2021; Sestelo, 2017).

The transformation of health into a financial investment has implications for how health is conceived and provided, and deviates part of the resources allocated to health activities. Several health actors have been incorporating principles, practices, and goals typical of financial institutions. This often results from the use of financial instruments and the association with financial actors, which requires them to adapt to the latter's standards and satisfy their requirements.[63] Accordingly, the expansion of health companies and insurers seems less dependent on the evolution of operational profits *per se* and more on how they would contribute to increasing shareholder value and investment returns. The extent of changes brought about by the need to generate financial returns extends to the materiality of service provision. It steers decisions on what kind of services will be provided, where, to whom, and at what costs and conditions, favoring those that can maximize financial gains and drive stock market appreciation. This can be seen, for example, when hospitals decide the profile of service provision prioritizing niches that maximize investment returns, or when insurance companies repress the value of benefits while increasing the volume of funds allocated in financial investments to maximize their financial results (e.g., Cordilha and Lavinas, 2018; Vural, 2017).

This transformation of health activities into investments reflects an underlying shift that goes beyond commodification (treating health as a commodity). Birch and Muniesa (2020) suggest that is impossible to understand the drivers of capital accumulation in the

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[63] This reflects a movement called by Aalbers (2019) as "corporate financialization", "*when traditionally nonfinancial firms become dominated by financial narratives, practices, and measurements and increasingly partaking in practices that have been the domain of the financial sector*" (p. 3).

latest stage of capitalism "*struggling within prevailing conceptions of the commercialization, marketization, and commodification*" (p. 9). They claim that the concept of "*assetization"* – "*turning things into assets*" (p. 11) is a missing piece in the puzzle. An asset is something that can generate returns in the future (Chiapello, 2020). Financial assets are intangible properties that do so by guaranteeing a claim on ownership or contractual rights to future payments from one entity over another. They can be owned or controlled, traded, and capitalized as revenue streams (Birch and Muniesa, *op. cit.*). Securities, loans, derivatives, and other instruments and contracts traded in financial markets are examples of financial assets. As commodification can be considered the underlying process underpinning privatization, a similar case could be made here with the concepts of assetization; if the process of commodification was associated with treating health care activities as commodities, attributing a "price" to it and putting it to be traded in markets for goods and services, assetization implies turning health care activities into assets, attributing a "risk" to them, and putting it to be traded in financial markets.

The transformations described above seem to support this idea. We have shown many instances where health activities have been treated as assets, as activities related to the financing and provision of medical care, ancillary services, insurance, and infrastructure were partially or entirely dissociated from their previous ownership structures and transformed into investment opportunities. Payments from households, governments, and companies directed to pay for such activities ended up partially appropriated by finance, through, for example, rights to ownership or returns on investments.

Narratives

The differences between earlier rounds of privatization and moves toward financialization go beyond the main actors involved. For example, the narrative built around PHS and the justifications for turning toward finance seem to have changed. Whereas in the past these systems were portrayed as inefficient and overspending, criticism today has not eliminated those views but focuses on presenting them as financially strapped. The chief argument used by those advocating in favor of incorporating financial capital and partnering with financial actors is not so much the opportunity to reduce expenditures or increase efficiency, but to increase investments and raise additional revenues. This has been observed particularly in studies on the use of financial instruments by public and non-profit actors (such as SIB and PPPs), as well as those considering events related to global health policies. Bayliss and Waeyenberge's (2017) study of PPPs, for example, observes that "*unlike the privatization of the 1990s, PPP policy is now driven far more by the availability of global finance than by the previously perceived potential for efficiency gains through privatization*" (p. 5).

Besides raising funds, other arguments supporting the turn to the financial sector underscore the potential of new strategies to reduce the costs of public financing and forge "virtuous partnerships" between different agents including investors, governments, for-profit companies, non-profit institutions, and the civil society. In particular, financialized strategies are often advertised as a solution to lower financing costs once financial markets

and institutions are seen as abundant and cheap sources of funds. These strategies would allow mobilizing idle capital voluntarily, which could not be raised through compulsory taxation, and the greater competition and availability of funds in private markets would render them supposedly cheaper than other forms of financing.[64]

Theoretical underpinnings

Another particularity of more recent developments is that the theoretical basis supporting financialization reforms seems weaker than in the case of privatization. Advocating in favor of incorporating private finance seems to be aligned with the belief that financial institutions and markets can value and allocate resources efficiently. It also suggests that the private financial sector is superior to the public sector in terms of the capacity of mobilizing funds in the economy. This in principle would indicate that the theoretical grounds for financialization rest on the assumptions of the financial system's neutrality and efficiency from neoclassical finance theories (section 1.1).

Interestingly, however, one can hardly find any mentions to finance theories in proposals that advocate in favor of bringing private finance into the health or the public sector. The resort to finance appears much more as a pragmatic solution for times of financial distress than as a theoretically informed policy option. Hunter and Murray (2019) seem to agree with this interpretation, as they note that "*this latest phase is characterized by a 'common-sense' policy position (...) that enormous volumes of private financial capital are necessary for promoting development in the health care sphere*" (p. 17).

Different paths, same driving force: austerity policies

The common element tying together reforms associated with privatization and financialization is the issue of austerity. Financialized strategies appear as a novel way to deal with the old challenge of maintaining and expanding public provision while public health revenues do not grow accordingly. If earlier rounds of reforms were focused on cutting and externalizing costs, the invitation now is to find ways to raise revenues without increasing taxation. The adoption of financial instruments for PHS financing is attractive for governments in the context of austerity as they can raise or borrow funds in the financial sector instead of tackling the challenge through policies that run counter to the neoliberal paradigm, such as taxing capital or allocating a higher share of public revenues to the health budget.

PHS, in particular, face strong incentives for turning toward the financial sector as they need to accommodate growing financing needs within ever more limited budgets. The implicit ideas are that traditional sources of public revenues alone cannot provide the necessary funds to maintain and expand access to health care, and private funding would be necessary for closing the gap. As observed by Bayliss (2016), "*growing financial deficits*

[64] The recognition of their capacity to mobilize capital voluntarily mentioned here has been first noted by Chiapello (2017).

puts attention on financial performance and legitimizes increasing penetration of financial capital in the health system" (p. 34). In a similar vein, Hunter and Murray (2019) suggest that the justification for promoting private investment in health care "*has been fueled by gaps in adequate resourcing of unified public systems*" (p. 4). Reinforcing this impression, research institutions have presented private investments as a "*solution to meeting rising demand in the face of severely constrained public resources*" (Fraser et al., 2018, p. 4).

This incentive to financialization is even more powerful in light of the limits for the continuity of typical privatization practices. Especially in the case of countries with PHS, governments cannot implement cost-cutting and coverage restriction measures *ad infinitum* without disrupting the system. Looking at the case of the NHS, Bayliss (2016) describes financialization processes as a policy alternative that finds space in a context where many spending cuts have already been made, and it seems increasingly difficult to cut further. As explained by the author, "*hospital trusts managed to withstand financial pressures, at first using traditional measures (pay freezes, cuts in management costs, reductions in tariffs for some services) but the strain is increasing. There is reportedly no more room to cut costs.*" In a similar vein, Whitfield (2015) contends that "*the new emphasis on financializing services*" seeks to "*create new pathways for the mutation of privatization*" in light of the exhaustion of traditional measures.

Impacts of financialization

Financialization has the potential to intensify adverse impacts associated with privatization and bring in additional ones. As discussed earlier in this section, the introduction of finance tends to influence decision-making processes in ways that secure and increase financial returns. For PHS, this means that governments will need to take into account the interests and needs of those agents along with (or above) those of the population. The need to repay debts, guarantee financial returns, and withdraw risks for investors is likely to push for measures to save funds by cutting on the quality, quantity, and employment conditions of the public system, as well as to shifting costs and responsibilities onto individuals. From that perspective, financialization is likely to intensify impacts already observed in the case of privatization. Tansey (2017), for example, affirms that "*squeezing profits for shareholders out of health and care services*" comes with risks such as *"deteriorating working conditions, worse pay, reduced staff levels, greater workloads, more stress, and shortcuts in training and protective equipment, all of which affect safety and quality of care*." (p. 2).

Moreover, the turn to the financial sector can also bring in challenges associated with characteristics inherent to financial markets, instruments, and institutions. The potential impacts of financialization measures in PHS can be considered based on observations taken from other areas of health care discussed in this text. First, the financial sector is known for its lack of transparency. Studies underscore that financial deals are largely based on private agreements and confidential information, often unavailable to the public and even to policymakers. In this way, while the use of public funding can in theory be traced, the same does not apply to private funds (Romero and Vervynckt, 2017; Stein and Sridhar, 2018;

Whitfield, 2015).

Adding to transparency problems, financialized strategies can spread public debt and expenditures items across different places of the public budget. Financial compensations, guarantees, and other forms of incentives can be accounted for separately from direct costs with public provision. Due to these "hidden costs", the resort to private finance may seem less expensive than traditional forms of public funding. This justifies why Whitfield (2015) insightfully describes financialized practices as the "*legalized off-balance sheet financing*" of public services. Evidence suggests that bringing in private capital often comes at a higher cost than existing forms of public financing (Bayliss, 2016; Bayliss and Waeyenberge, 2017; Hermann, 2010; Loxley and Hajer, 2019; Ryan and Young, 2018; Whitfield, 2006). According to Whitfield (2015), "*the increase in investments is a myth: the public sector has to pay for the investment plus the profits to investors and is therefore not additional investment. It replaces public investment at a much higher cost*" (p. 9). Yet, the lack of reliable and accessible data makes it difficult to determine the true costs of such strategies (Loxley and Hajer, 2019; Romero and Vervynckt, *op. cit.*).

The lack of transparency is closely connected with accountability issues. The extensive network of actors involved in financial operations and exchanges on secondary markets further adds to the complexity of the task of "following the money". It becomes virtually impossible to know in detail the origins of the funds coming from financial intermediaries and investors, as well as the final destination of the payments addressed by the public sector later on. Also, public policy-making processes become subject to stronger vested interests. By providing money, actors such as investors, banks, and financial institutions are likely to assert greater influence in policy decisions. These are some of the reasons to argue that there is much less space to subject the decisions in the use of public funds to popular scrutiny, meaning a loss of democratic participation (Dentico, 2019; Whitfield, 2015)

Lastly, financial markets and activities are known for being extremely volatile, operating under "boom and bust" cycles (Stein and Sridhar, 2018). Depending on financial markets to finance policies means exposing them to the "casino dynamics" of financial markets, which, in the case of health policies, means putting the health of the most vulnerable at great risk (Dentico, 2019).

There is no reason why such issues could not be extended for PHS, a discussion that is the core research question of our research.

Bridging concepts together: privatization as a driver of financialization

Far from claiming that privatization was replaced by financialization, we contend that these are interconnected and mutually reinforcing processes that together are reshaping the landscape of PHS. This is in line with Fine and Hall's (2012) assertion that, "*as finance has increasingly come to the fore, so it has both promoted and benefited from privatization*" (p. 53).

The existing literature offers us two sets of arguments to support this claim. On the

one hand, some studies argue that privatization can act as a driver of financialization. One reason is that privatization requires regulatory shifts that enable and expand the possibilities of profit-making in activities related to health financing and provision, facilitating the creation of financial undertakings at a later moment (Hunter and Murray, 2019; Vural, 2017). Along these lines, Fine (2009) argues that some sort of privatization is necessary for financialization in the public sector. This is because it is the process of privatization (in its broadest sense as reforms that introduce market logic into the public sector) that creates payments for goods and services where these did not exist before. In doing so, it introduces monetary flows in public services, which can then be manipulated to create financial assets and returns. In the case of health, establishing internal markets, introducing user charges, and contracting out services are examples of privatization measures that can create revenue flows, potentially leading to financialization. As explained by Bayliss et al. (2017), "*financialization can prosper where there is not necessarily commodity production but the presence of the "commodity form" by which is meant monetary payments (...) which generate revenue streams that can be securitized as assets and be speculatively traded as interest-bearing capital*" (p. 5; see also Fine and Bayliss, 2016).

Rather than unintentionally promoting financialization, these authors contend that privatization is now at least partly motivated by the very own prospects of creating assets and returns. According to Bayliss (2016),

> [Public] health services are interpreted in terms of their potential for financial gain in a more creative way than was the case twenty years ago. **Attention is paid to revenue streams and asset values as well as the potential for securitization to enhance shareholder distributions.** This is in contrast to the 1980s where privatization was seen as a way to improve productive efficiency by bringing in private owners. (p. 42, emphasis added).

Financialization as a driver of privatization

On the other hand, there are several reasons to think that financialization boosts privatization. The most relevant one is that the accumulation and internationalization of financial capital allow for a vast sum of available funds looking for profitable investment opportunities. In this context, privatization would appear a prominent outlet for excessive capital (Huffschmid, 2009). According to Fine (2008), "*the volume and range of financial services that have been made available [in the period of financialization] have given rise to a wealth of 'idle capital' that makes itself busy by the pursuit of privatization*" (p. 15). On top of investment returns, Sawyer (2009) adds that the financial sector can profit from these developments in many other ways such as through fees, commissions, and other sources of income generated by arranging processes of privatization (see also André and Hermann, 2009). Huffschmid (*op. cit.*) concurs with this view and adds that the reason privatization has been so intense can be at least partially explained by the fact that it meets the interests of both finance and the State:

> In the context of growing private financial assets seeking investment opportunities

> and at the same time growing pressures upon public finances, privatization appears as a solution to the problems of both the wealthy [investors] and the State: it gives the former a new area for financial investment and relaxes the financial constraints for the latter (p. 54).

Other authors highlight that the injection of financial capital boosts the growth of the market's largest private health companies and reinforces existing trends for concentration, creating major players with political and economic power to pressure governments in favor of privatization (Bahia et al., 2016; Sestelo, 2018; Vural, 2017).

More recently, it has become clear that financial capital also promotes privatization in a more straightforward way; public projects financed by financial firms and investors tend to have an ideological bias in favor of private actors for building, maintaining, and operating the services as these are considered more efficient and innovative. The preference for private providers has been evidenced in cases where public services were financed by private investors via SIBs and PPPs (e.g., Andreu, 2018; Bayliss, 2016; Loxley and Hajer, 2019).

This chapter introduced the topic of PHS and argued that the concept of financialization could help to better understand recent reforms in these systems. The joint analysis of the dynamics of privatization and financialization carried here, including the differences and interdependencies between these processes, is crucial for better understanding the phenomena under discussion. Surprisingly, to date, there have been few efforts to systematize these differences and connections, and even less so for the specific case of PHS. Given the significance of this discussion, we offer a table in Appendix 1 that systematizes the main ideas presented in this chapter, including the fundamental characteristics of each of these processes and how they seem to relate to each other. In the following chapters, we will move from the theory to practices, investigating how these developments have unfolded in two universal systems over the past three decades.

CHAPTER 3. THE FRENCH SYSTEM: PIONEERING FINANCIALIZED STRATEGIES IN PHS

Since the mid-1990s, the French PHS, *Assurance Maladie*, has been subject to major changes in financing marked by an increasing reliance on financial capital. The State was directly responsible for the implementation of financialized strategies within the system. Such strategies mobilize resources from financial markets and reach a degree of complexity hardly, if ever, observed in other countries. Although part of them altered the financing of the Social Security system more broadly, they are closely connected to the health system and had a direct impact upon it. This is because the French PHS is one of the core pillars of the Social Security system in the country, and is traditionally the branch most in need of additional funding. The financing requirements of this branch were an important justification used by the government to turn to financial capital in order to manage Social Security accounts.

We begin our analysis by presenting the institutional features of the French Social Security and health care systems, as well as the latter's evolution over the past half-century. We then examine three sets of transformations through which the financing of public health care became increasingly dependent on financial capital. Looking at long-term financing, we describe how the Social Security system started issuing securities for refinancing its debt in the financial markets. The following section turns to short-term financing, showing how a similar strategy was adopted to cover expenses falling due in the near future. We conclude by discussing changes in hospital financing, namely the creation of programs to fund the public hospital infrastructure through bank loans and debt bonds.

3.1. Social Security and public health care in France

The French PHS is embedded in a more comprehensive institutional framework known as the Social Security system. Its principles of organization, financing, and provision are closely linked to those governing Social Security at large. Moreover, part of the policies described in this chapter targets the broader system of Social Security and impacts all its branches – including that which finances the health system. To better understand how the French PHS works and the ways in which it connects to the financial sector, it is therefore necessary to first describe this broader institutional framework to which it belongs.[65]

3.1.1. The French system of Social Security

The French Social Security system (*la Sécurité Sociale*) was created in 1945, following a regional trend of expansion of welfare policies in the post-war period. The 1946

[65] The information presented throughout the present and following sections is based on Abecassis et al. (2018), Abecassis and Coutinet (2021), ACOSS (2018a, 2018b), Batifoulier (2015), Batifoulier et al. (2018), Batifoulier and Touzé (2000), Damon and Ferras (2015), Direction de la Sécurité Sociale (2018), and Palier (2010a).

Constitution formally introduced Social Security in the country. "The French nation", as written in the text, committed itself to protect citizens against risks and contingencies related to the loss of income or well-being that could prevent them from attaining socially acceptable living standards (France, 1946).

A number of fundamental principles were set out during the system's creation, expressing its core values and goals. Among the most important, we can mention national solidarity (all individuals should participate in the system), redistribution (part of resources should go from the most to the least favored ones), mutualization (the participants would contribute according to their means and receive according to their needs), universality (the system would cover the entire population of the country), and integrality (it should protect against a wide array of social risks). These principles can be found at the very beginning of the current legislation governing the Social Security system (France, Social Security Code, Article L111-1).

In practice, as of 2018, the system of Social Security was divided into four branches:[66]

- The Illness branch (*branche maladie*) covers health-related risks. It focuses on benefits (in cash and through direct public provision) to protect against risks related to the loss of physical and mental health. In our analysis, it represents the French PHS;
- The Retirement branch (*branche retraite*) covers events related to aging, providing retirement pensions and allowances;
- The Family branch (*branche famille*) covers events related to family costs and poverty. It provides minimum maintenance benefits ("safety nets"), birth and early childcare benefits, housing subsidies, and other welfare benefits;
- The Accidents at work and occupational diseases branch (*branche accidents du travail et maladies professionnelles*) covers injuries and illnesses from work activity. It provides benefits ranging from daily indemnities to lifetime disability pensions.

The French Social Security system follows the logic of social insurance, inherited from the earliest forms of Bismarckian State protection in the 19th century (chapter 2). In reality, it is not a single system, but the combination of different public schemes separated according to one's occupational status and sector of activity. When these schemes were first created, the prevailing idea was that they would be governed together by employers and employees, and financed by both via contributions on wages. These systems underwent several reforms over the years, some of which have distanced them from these principles (Damon and Ferras, 2015; Palier, 2010c; Vahabi et al., 2020). Yet, the logic "social

[66] The description presented here refers to the organization of the system for the largest part of the period under investigation (1990-2018). It does not incorporate eventual changes that may have been carried out in the following years.

insurance", based on different funds that should (at least in principle) be funded and governed collectively, separated from the central government, remains in place.

As of 2018, the Social Security system was formed by three "basic" regimes (*régimes de base*): the General Regime, the regime for agricultural workers, and the set of "special regimes" dedicated to particular categories of workers (e.g., public servants, the military, and employees of specific public enterprises).[67] These are mandatory schemes covering the full range of risks guaranteed by the Constitution. The General Regime is the focus of our analysis. It covers most wage-earners from the private sector, the self-employed, and those not eligible for any other scheme. Almost 90% of the population is covered by this regime (DSS, 2018). In addition to the basic schemes, there are several complementary schemes for pensions (*régimes complémentaires*), also mandatory and separated according to occupational status. By the late 2010s, there were over forty complementary pension regimes.

In France, the "State" and "Social Security" are considered different spheres of the public administration. Each has its own budget, with specific sources of revenues.[68] The chief sources of revenues for Social Security are earmarked taxes known as "social contributions". These include contributions on the payroll paid by employers and employees (*cotisations*) and general contributions levied on different sources of income such as wages, retirement pensions, property income, and investment income (*contributions généralisées*). Social Security also receives funds from general taxation, which enter the system through State transfers. In 2017, approximately 55% of Social Security's revenues came from contributions on the payroll, 20% from one general contribution (the "general social contribution", named *Contribution Sociale Généralisée*), and 25% from State transfers and proceeds from other contributions, taxes, and fees (DSS, 2018). This list comprises the permanent sources of revenues of the Social Security system. It does not take into account the "non-permanent" revenues that Social Security raises in order to manage its accounts, including in financial markets, which are discussed in the following sections (see Figure 3.1).

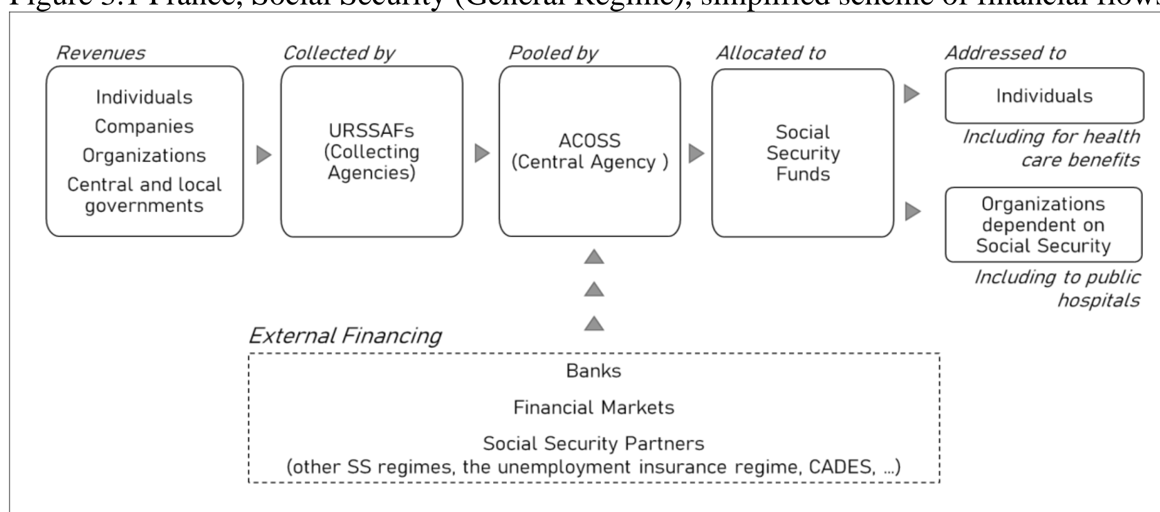
The circuit from tax collection to benefit payments depends on a network of bodies, each one in charge of a specific stage – collection, centralization, and redistribution of revenues. The collection unions (*Unions de recouvrement des cotisations de sécurité sociale et d'allocations familiales* – URSSAFs) are in charge of gathering revenues from contributors (companies, public administrations, independent workers, and individuals) and

[67] The term "Social Security system" is usually employed to refer to the ensemble of basic regimes. Nonetheless, it is possible to find other applications. Some use the term to refer to the group of all mandatory basic and complementary schemes, or even the whole scope of institutions classified as "Social Security administrations" (see footnote below). For reasons of scope and data availability, our discussion refers to the General Regime (except when explicitly stated otherwise).

[68] The public sector in France is divided into four spheres of administrations: the State, Social Security administrations, other central government agencies, and local public administrations. Social security administrations comprise the compulsory Social Security regimes, the unemployment benefit scheme, auxiliary funds (such as the Fund for Old-Age Solidarity – Fonds de Solidarité Vieillesse/FSV, the Pension Reserve Fund – Fonds de Réserve pour les Retraites/FRR, and the Social Debt Amortization Fund – Caisse d'Amortissement de la Dette Sociale/CADES), and "organizations dependent on social insurance" (public hospitals, private non-profit health establishments, and social works).

addressing them to the Central Agency of Social Security Organizations (*Agence Centrale des Organismes de Sécurité Sociale* – ACOSS). The Central Agency, ACOSS, pools the resources and distributes them across the Social Security branches. This transfer is made through the Social Security Funds (*Caisses de Sécurité Sociale*), which can be understood as "accounts" that each Social Security branch maintains in the Central Agency. The general regime has three national Social Security Funds: for the Illness and Occupational injuries branches (combined); the Retirement branch; and the Family branch. The National Funds and its subordinated local funds execute the payment of benefits to individuals and, depending on the nature of the benefit, also to public and private entities. Apart from this central circuit, Social Security also reaches for external sources of financing that include financial institutions and markets, the State, and other public agencies.

Figure 3.1 France, Social Security (General Regime), simplified scheme of financial flows



Source: author's elaboration. Refers to the General Regime of Social Security.

The French system can be considered significantly redistributive compared to those of other countries. One possible way to assess this capacity of redistribution is by comparing individuals' disposable income *before* and *after* taxation and public transfers, the latter being a proxy for Social Security benefits. Data from the OECD database suggest that progressive taxation and social transfers were responsible for a 43% drop in the measure of income inequality in 2015, from a Gini coefficient of 0.52 before taxes and transfers to 0.3 after.[69] For the sake of comparison, the average reduction in OECD countries was 34%, from 0.47 to 0.31. Unfortunately, the data do not allow separation of the effects from taxation from those of social transfers. However, the argument can be reinforced by the fact that the proportion of people living below the poverty line in France (half of the median income of the total population) was 8% in this year, compared to 12% for the OECD average (OECD, 2021b).

[69] The Gini coefficient is a measure of income inequality that ranges from 0 (total equality, when all individuals would have the same share of the national income) to 1 (total inequality, when one individual would hold all the national income).

By contrast, the system is criticized for creating and intensifying some forms of inequalities. These derive mainly from the fact that the public insurance regimes that form the Social Security system operate according to different rules and do not offer the same levels of coverage to the beneficiaries.

3.1.2. The French public health system: Assurance Maladie

Overview

Each Social Security regime has its own health insurance scheme, with different rules for enrollment, contribution, and benefits. The term *Assurance Maladie* (Ameli) is usually employed in a broad sense to encompass the public health insurance schemes provided by the various regimes of Social Security. This study focuses on the public health insurance system from the General Regime, which, as observed in the previous section, covers the vast majority of the population.[70]

Besides working in line with the general principles of Social Security, Ameli must also follow an additional set of principles that includes equality of access, solidarity, and quality of provision. As expressed in the Social Security Code,

> The Nation affirms its commitment to the universal, compulsory and solidarity nature of health insurance. Regardless of age and state of health, each social insured person benefits from protection against the risk and consequences of illness, which he or she finances according to his or her resources (French republic, Social Security Code, Article L111-2-1).

The revenues to finance Ameli come primarily from the Social Security system. Consequently, social contributions are its main source of funds. In 2017, 43% of Ameli's revenues came from contributions on wages, 31% from the General Social Contribution, and 26% from State taxes and other sources of revenues (DSS, 2018). Additionally, health benefits provided under universalization programs (see below) are co-financed by a fee levied on complementary health insurance premiums.

As a model of social insurance, part of Ameli's expenditures is addressed to individuals in the form of reimbursements or cost-coverage for medical goods and services acquired either in the public or the private sector. The extent of public coverage depends on a number of factors, namely the type of good or service and the beneficiary's health and financial conditions. As a general rule, by 2018, Ameli reimbursed approximately 70% of the standard price for medical appointments and laboratory tests, 80%-90% of hospitalization costs, 60% of services and goods related to optics and orthopedics, and from 0% to 100% of drugs.[71] The share of costs paid by Ameli is referred to as the "obligatory

[70] Unless stated otherwise, the term "Assurance Maladie" will be employed here in reference to the public insurance scheme of the General Regime, and used interchangeably with the French PHS and the "Illness branch" of Social Security (the most common term used in official reports).

[71] The standard price, or "convention tariff", is a fixed price determined *ex-ante* between Ameli and health professionals. See www.ameli.fr/assure/remboursements.

part". Under certain conditions, health professionals may bill additional charges not covered by the public system (*dépassement d'honoraires*). This does not apply to all circumstances and may vary depending on the patient's financial situation, the practitioner's decision, and the complexity of the procedure, among other factors.

After public coverage, the remaining payables are left to the patient and can be paid either directly (*out-of-pocket*) or by a private insurance plan. This part is known as the "complementary part". Therefore, the public and private insurance segments in France follow a complementary logic (OECD, 2004): private insurance works *in tandem* with the public system, covering part or all of the residual costs left unpaid by the latter. Approximately 95% of the French population is covered by "complementary" health insurance plans (DREES, 2019b). Such a widespread presence can be traced back to the important role of mutual companies in covering health risks prior to 1945. With the creation of Social Security, these organizations managed to preserve a great part of their original fragmentation and autonomy, and maintained an important role in the full coverage of health care costs.

Despite the fast growth of for-profit companies in the last decades, complementary insurance remains mostly in the hands of non-profit institutions, an old tradition from the French mutualist movement (*mouvement mutualiste*). In 2017, 78% of establishments proposing complementary health insurance contracts were classified as non-profit, receiving 70% of the total revenues from complementary health insurance premiums (DREES, 2018a). As shown by some authors, however, French non-profit insurance funds are increasingly abandoning values of solidarity and adopting strategies typical of for-profit insurance companies (Abecassis et al., 2018, 2017, 2014; Abecassis and Coutinet, 2021).

Some activities and programs carried by Ameli are financed directly by the State, not by Social Security. This is the case for certain actions related to prevention, medical and pharmaceutical research, professional training, health insurance programs for the poorest or irregular residents, endowments for military hospitals, and emergency medical care.

Concerning the system's regional organization, there are institutions entrusted with implementing the policies and adapting them to the specificities of each region, namely the Regional Health Agencies (*Agences Régionales de Santé*, ARS). Still, in comparison to other countries, the financing and organization of the French PHS is considerably centralized at the national level.

Besides public insurance, the French PHS also provides health care services directly, through public hospitals. The public sector is responsible for the largest share of hospital care in the country. In 2016, 62% of hospital beds were in public health establishments. These are mostly financed by Ameli, which provides around 70% of their revenues. Individuals, private insurance, and the State together account for the remaining 30% (DREES, 2018b).[72]

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[72] Ameli and public hospitals have separate budgets. The latter are still part of the Social Security system, but they are classified as a special category of entities known as "organizations dependent on social insurance", separated from social insurance schemes.

The trajectory toward universalization

Although the principle of universal health care dates back to the creation of Social Security, the extension of the right to participate in public schemes to all the population was a gradual process, formally concluded only in the late 1990s. The main efforts to extend social protection started in the 1960s, with the creation of Social Security schemes for specific professional activities in response to a growing and increasingly diversified working class. Despite substantial signs of progress toward universalization, until the 1990s, there were significant gaps in terms of the population covered by the public system. Most importantly, a significant number of individuals could not benefit from Social Security benefits because their employment status did not make them eligible for any existing scheme.

At the end of the century, the State initiated a more consistent strategy to universalize access to health care. This came with the creation of programs seeking to guarantee access to both public and private insurance. In 1999, the government universalized access to public insurance by altering the eligibility criteria of the General Regime of Social Security. The Basic Universal Illness Coverage program (*Couverture Maladie Universelle de Base*, CMU) gave any individual unaffiliated to a mandatory scheme the right to enroll in the General Regime. Yet, administrative barriers often prevented potential members from either joining the scheme or staying in it after a change in their personal or professional status. In order to address those issues, in 2016, the CMU was transformed into the Universal Illness Protection (*Protection Universelle Maladie*, PUMA). With PUMA, residence criteria became the norm; any individual living in France with a permanent and regular status was automatically entitled to the General Regime. As of 2015, two million people in the General Regime joined the scheme through such programs (Fonds CMU, 2016). In parallel, in 1999, the government also created the State Medical Aid (*Aide Médicale de l'État*, AME) for irregular residents, providing health assistance to them. In this case, the participation in the scheme is temporary and subject to conditionalities.

The CMU/PUMA programs grant the same extent of insurance coverage as that received by members who join the general regime of Social Security through traditional channels. This means it ensures the share of health expenses covered by the public system, the "obligatory part". Consequently, the members who entered the system through these programs are still left with a "complementary part" to pay. The costs not covered by Ameli could lead individuals to postpone or refrain from seeking aid. The generalization of private insurance represented, therefore, another core pillar of the government's universalization strategy. The latter created programs to extend access to private insurance schemes seeking to cover outstanding costs. The Complementary Universal Illness Coverage program (*Couverture Maladie Universelle Complémentaire*, CMU-C) was implemented in 1999, together with the CMU. The CMU-C entitles low-income individuals to complementary health insurance free of charge, chosen from a set of institutions selected by the government.

In 2004, those earning slightly above the maximum eligible for the CMU-C received support with a new program called the Aid for the Acquisition of a Complementary Health

Plan (*Aide à l'Acquisition d'une Complémentaire Santé*, ACS). The ACS granted discounts on premium payments, also with selected institutions. By the end of 2017, 5.5 million people benefited from the CMU-C and 1.6 million from the ACS, amounting to around 10% of the French population (Fonds CMU, 2016). Both programs, CMU-C and ACS, were financed by taxes levied on complementary insurance premiums. Lastly, the government imposed the generalization of complementary health insurance for private sector workers in 2016 (*Généralisation de la Complémentaire Santé*), obliging all companies to provide complementary health insurance plans for their employees.[73]

Individuals are also entitled to the full coverage of health care costs if they suffer from illnesses that require expensive or continuous treatments (*Affections de Longue Durée*, ALD). The right to receive special treatment in these cases exists since the creation of Social Security, but the health conditions included in this category and the length of the support have varied over time. As of 2017, there were thirty health conditions allowing individuals to obtain free treatment, and more than ten million people enrolled in the general scheme were classified as ALD patients (Assurance Maladie, 2018).

The path of reforms in the neoliberal period

From 1975 to 2015, the Social Security system was subjected to a series of structural changes, including a constitutional reform (1996) and frequent adjustments imposed by two organic laws (1996 and 2005) and eighteen financing laws (from 1997 to 2015) (Franchet, 2015). There were also many other measures after this period. Along with the reforms in the Social Security system, there were numerous reforms targeting the Illness branch (Ameli).

Until the 1980s, Ameli underwent changes in its institutional framework, eligibility criteria, and value of benefits, mostly to expand public coverage and provision (and consequently public spending). After this decade, the government started a more systematic process of reforms in the opposite direction. The government's reform agenda, aimed at achieving "financial equilibrium", imposed a combination of measures to increase revenues, curb expenditures, and increase the State's grip on decisions relative to the Social Security system.[74] A particularly important set of measures to contain public coverage and costs was that seeking to increase the share of health care costs borne by patients. The rise in co-payments was done by introducing or increasing co-insurance devices (*ticket modérateur),* daily hospital charges (*forfaits hospitaliers),* and flat out-of-pocket charges (*forfaits* and *franchises*).[75] While these measures were largely justified as a way to "foster responsibility"

[73] This last measure is subject to controversy in terms of its stated intention of addressing gap coverages and reducing inequalities in access to health care. Several authors contend that insurance companies are likely to benefit more from this rule than workers (see, for example, Abecassis et al., 2017).

[74] For extensive reviews of Ameli reforms, see IRDES (2017, 2015), Jansen (2016), Nay et al. (2016), and the Projects for the Financing Laws for Social Security (Assemblée Nationale, various years). The measures listed in this section were extracted from these sources.

[75] Co-insurance refers to the share of costs not reimbursed by Ameli and left to the individual or private insurance scheme. Daily hospital charges are fixed daily fees for hospital stays. Flat out-of-pocket charges are fixed fees that apply to each use or purchase of certain services and goods, including *forfaits* (for consultations, medical procedures, exams, and analysis), and *franchises* (for drugs, paramedical procedures, and medical transportation).

in patients (creating disincentives for supposedly unnecessary demands), they also allowed for the relative decline in the costs covered by the French PHS in many areas. Along with that, there were measures to limit expenditures by service providers, namely through the imposition of budget ceilings in public hospitals and for outpatient care providers.

In the 1990s, the deterioration of Social Security accounts (section 3.2) led the government to intensify measures for increasing revenues and curbing costs in the PHS. It sought to raise funds by increasing rates on contributions, withdrawing caps on existing ones, and introducing the General Social Contribution, which became one of the primary sources of revenues for Social Security. Meanwhile, the government continued to implement devices to control spending, including by diminishing the share of Ameli reimbursements for certain medical consultations, examinations, and drugs.

In the second half of the decade, the Social Security system underwent a structural reform following which cost-containment measures were implemented in a more systematic fashion. The 1996 Constitutional Reform of the Social Security system created a new category of laws, the Social Security Financing Laws (*Lois de Financement de la Sécurité Sociale* LFSSs). With these laws, Social Security policies started being formally subjected to guidelines and spending targets that were voted by the Parliament each year. The government also created a specific set of spending targets for the PHS, the Assurance Maladie's National Spending Target (*Objectif National des Dépenses d'Assurance Maladie*, ONDAM). Through this device, the government could set an expected growth rate for the health care expenditures of the following year and adopt the necessary measures to achieve such targets.

The financial pressures on Ameli continued into the 2000s and 2010s. The government continued to diminish public coverage for part of health goods and services as well as to impose budgetary rules. In 2004, the PHS underwent a far-reaching institutional reform (France, 2004). The Assurance Maladie Reform took co-payments and budgetary rules to a new level. The most telling example was the redesign of the traditional form to access public health coverage, implementing a protocol for patients to follow (*parcours de soins coordonnés*) so they could benefit from the full reimbursement expected from the public system. At the same time, familiar measures continued, such as the creation or increase of co-insurance devices and stricter conditions to access benefits.

In the 2010s, the efforts to reduce spending were diversified from patients toward hospitals, health care professionals, and the pharmaceutical industry. While the introduction of devices increasing the share borne by patients continued, these were combined with more significant shifts in the conditions and values of transfers from Ameli to health professionals and establishments. The diversification of measures widened to reach cost-saving agreements for hospital procurements and the de-listing or decrease in reimbursements for drugs, to name a few.

The public health system today

The magnitude of the French public health system can be perceived in figures (Table 3.1). The health sector has a significant weight in the economy, accounting for around 11%

of the French GDP in 2016. The public sector exerts a chief role in health spending, far greater than the share borne by the private sector (including individuals and insurance). Government spending on health accounted for 8.4% of GDP in this year, while the average in OECD countries was 6.1%. Approximately 73% of total health spending was borne by the public sector, against 70% in the OECD region. Public health spending *per capita* was also above the OECD average, US$3,100 against US$2,396.

Table 3.1 Health spending, total and public, France and selected regions, 2016

	Share of total health spending (%)	Share of the GDP (%)		Per capita spending (USD)	
	Public	Public	Total	Public	Total
France	73	8.4	11.5	3,100	4,268
United Kingdom	80	7.9	9.9	3,268	4,066
United States	50	8.6	17	4,977	9,878
OECD average	70	6.1	8.8	2,396	3,426
World average	52	3.5	6.6	686	1,028

Source: WHO (2020). Own elaboration. Public spending refers to domestic general government health expenditure (GGHE-D). Per capita spending in current values. The share of public spending in total spending may vary depending on the selected indicator, for reasons related to methodology and rounding.

The French system was ranked the best one in the world by the World Health Organization (WHO, 2000) at the turn of the century. On the positive side, several indicators of population health are above the OECD average. The estimated life expectancy at 65 years old, largely associated with the quality of access to health care, is one of the highest among wealthy countries. In 2015, French women aged 65 were expected to live an additional 23.5 years, the second longest length in the OECD countries, while men were expected to live an additional 19.4 years, ranking fourth place (OECD, 2021b).

On the negative side, France trails far behind neighboring countries in more recent classifications, coming in 20th place among 195 countries in a 2017 ranking published by the specialized journal "*The Lancet*" (Fullman et al., 2018). The health system is subject to criticism due to the creation or intensification of inequalities in access to health. First, the quality of care is uneven across different areas of provision. Accordingly, some health indicators are a cause for concern. Child mortality, for example, was the 8th highest among 23 OECD countries in 2015 (OECD, 2021b).[76] Second, there are geographical inequalities, with a chronic shortage of health professionals in poorer regions. Third, one can mention social inequalities in access to health, with beneficiaries enjoying different degrees of protection according to the scheme to which they belong. Despite improvements in the last decade, co-payments still refrain individuals from seeking health care. Data show that the least favored individuals withdraw from medical services more often than the richest, and financial costs are cited as the main reason leading them to do so. In 2016, the share of the population refraining from seeking care was 4% for the population at large and 8%

[76] Measured as the number of deaths of children aged under one year old per 1,000 live births.

considering only unemployed individuals (DREES, 2018c).

3.2. Ameli's accounts in perspective

The turn of the French Social Security system toward financial markets by the late 20th century coincides with two parallel trends: the acceleration of the process of financialization of the global economy, and the deterioration of the system's financial accounts. Around this time, financial imbalances in Social Security began to serve as a justification for reforms in PHS. Some of these reforms were in the direction of reducing expenditures, as described in the previous section. But these imbalances also led to another and far less discussed set of reforms, those leading the system to resort to financial capital to raise additional revenues. To contextualize this turn toward the financial sector, this section reviews the evolution of Social Security and public health accounts over this period. This will provide the background to examine the adoption of financialized strategies in the last part of this chapter.

Social security results, meaning the balance between the revenues and expenditures of its four branches combined, presented positive values throughout the 1980s (DREES, 2008). During the first half of the 1990s, this balance started eroding at a fast pace, reaching a deficit of *minus* €14 billion in 1995. More than half came from the Illness branch (Ameli), which attained a deficit of €8 billion this year.[77] In the second half of the decade, the gaps between revenues and expenditures started to close again, leading to a positive balance by the early 2000s (Table 3.2). These improvements, however, were short-lived; after 2002, both the Social Security system and the Illness branch started facing deficits again due to a combination of factors including the adverse macroeconomic context of the period, decelerating revenues, and expenditure growth (Assemblée Nationale, 2002). The accounts started recovering again in 2004 amidst increased economic growth and the far-reaching reforms imposed on the system. But this recovery was once again temporary; following the Great Financial Crisis of 2008 and the Eurozone crisis of 2009, the accounts of both Social Security and the health branch reached a new bottom. The 2010s decade presented a slow but steady recovery, with diminishing deficits until 2018.

The table below also reveals the weight of the PHS, represented by the Illness branch, in Social Security accounts. The former absorbs most of the latter's budget and is the primary source of the so-called "Social Security deficits" (when revenues fall short of expenditures for a given year). In 2017, Ameli received about half of the revenues transferred from Social Security to its branches. Its deficit (€4.9 billion) was even larger than that of Social Security at large (€2.2 billion), as the latter was partially offset by positive results in other branches.

[77] Although historical trends are clear, we do not make a continuous data series since the 1980s due to changes in methodology and data sources that occurred since then (cf. DREES, 2008). Unless stated otherwise, figures in this section are in constant values of 2018, adjusted according to the Consumer Price Index (IPC), and refer to the General Regime.

Table 3.2 France, Social Security and Illness branch (General Regime), financial balance, 2000-2017, billions of euros of 2018 and as a % of GDP

	2000	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*
Billions of euros of 2018																			
Illness branch	-2.1	-2.7	-7.6	-13.6	-13.9	-9.4	-6.8	-5.2	-4.9	-11.7	-12.6	-9.2	-6.2	-7.1	-6.7	-6.0	-4.9	-5.0	-0.7
Social Security	0.9	1.4	-4.4	-12.5	-14.2	-13.6	-10.1	-10.8	-11.2	-22.4	-26.1	-18.6	-13.9	-13.0	-10.0	-7.0	-4.2	-2.2	1.2
% of GDP																			
Illness branch	-0.1	-0.2	-0.5	-0.8	-0.8	-0.5	-0.4	-0.3	-0.2	-0.6	-0.6	-0.4	-0.3	-0.3	-0.3	-0.3	-0.2	-0.2	0.0
Social Security	0.1	0.1	-0.3	-0.8	-0.8	-0.8	-0.5	-0.6	-0.6	-1.2	-1.3	-0.9	-0.7	-0.6	-0.5	-0.3	-0.2	-0.1	0.1

Source: author's elaboration based on CCSS (2000-2018). Real values of 2018 adjusted for inflation according to the Consumer Price Index. For 2018, estimated GDP. Social security refers to the sum of the four branches (illness, old-age, family, and workplace contingencies).

Regarding Ameli's deficits (Table 3.3), their causes are a matter of dispute. As a general rule, the government described expenditure growth as the main cause of deficits. Nevertheless, some studies show that the country's economic slowdown in the 2000-2010 decade and the consequent decrease in revenues played a major role in the results observed in this period (Cornilleau, 2009, cited by Nay et al., 2016). By breaking down Ameli's accounts over the last decade, one can see that expenditures grew slower than revenues, challenging the widespread idea that these financial imbalances were primarily driven by rising costs.

Table 3.3 France, Illness Branch (General Regime), revenues, expenditure, and balance, 2000-2017, billions of euros of 2018 and % growth rate

	2010	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*
Billions of euros of 2018								
Revenues (I)	154.6	158.1	162.2	163.7	167.0	172.6	200.2	205.1
Expenditures (II)	167.2	167.2	168.4	170.8	173.7	178.6	205.2	210.1
Balance (I-II)	-12.6	-9.2	-6.2	-7.1	-6.7	-6.0	-4.9	-5.0
Growth rate (% relative to the previous year)								
Revenues	-	4.4%	4.7%	1.9%	2.5%	3.5%	16.2%	3.4%
Expenditures	-	2.1%	2.7%	2.4%	2.2%	2.9%	15.1%	3.4%

Source: author's elaboration based on CCSS (2011-2018). Real values of 2018 adjusted for inflation according to the Consumer Price Index.

The structure of health care spending in France reveals distinctive roles for public insurance, private insurance, and individuals. Health care financing is generally assessed through the indicator "consumption of medical care and goods" (Table 3.4).[78] The values

[78] The "Consumption of Care and Medical Goods" (*Consommation de Soins et de Biens Médicaux, CSBM*) is a popular indicator to assess health care spending in France. It discriminates the consumption of medical services and goods according to categories and sources of financing. The central categories of care and goods

suggest that public health spending became increasingly concentrated on the most expensive, riskier, and complex area of service provision – hospital care. The share of hospitalization costs in the country covered by Ameli increased from less than 60% in the 1960s to more than 90% in the 1990s. In other areas, the public share in total spending remained significantly lower and even decreased in the case of ambulatory care. As of 2015, the Social Security budget covered 91% of the total consumption of hospital care, against 65% for ambulatory care, 69% for drugs, and 55% for other medical goods.

Table 3.4 France, Social Security's share in the consumption of care and medical goods, 1960-2015, % of total spending in each category

	1960	*1970*	*1980*	*1990*	*2000*	*2010*	*2015*
Hospital care	59%	79%	88%	92%	92%	91%	91%
Ambulatory care	58%	74%	77%	67%	66%	63%	65%
Transportation	100%	100%	96%	96%	95%	94%	93%
Drugs	49%	64%	66%	61%	65%	67%	69%
Other medical goods	30%	39%	45%	45%	50%	54%	55%

Source: author's elaboration based on DREES (2020, 2017). Includes all statutory regimes.

The Social Security system took on increasing responsibility for health care financing until the 1980s; from then on, its participation stagnated at around 77% of total spending (Table 3.5). The State's participation – meaning that of central and local governments – fell significantly in this period, from 10% in the 1960s to 1% in 2015. Offsetting these trends, the participation of complementary insurance and households in health costs declined until the 1980s and became relatively stable afterward, at around 13% and 9%, respectively.

Table 3.5 France, consumption of care and medical goods by source of funding, 1960-2015, % of total spending

	1960	*1970*	*1980*	*1990*	*2000*	*2010*	*2015*
Social Security[1]	55%	73%	80%	77%	77%	76%	77%
Central and local administrations[2]	10%	6%	3%	1%	1%	1%	1%
Complementary organizations and households[3]	36%	22%	17%	21%	22%	22%	21%
Complementary organizations	-	-	-	*10%*	*12%*	*13%*	*13%*
Households	-	-	-	*11%*	*10%*	*9%*	*8%*

Source: author's elaboration based on DREES (2020, 2017).[1]Includes all statutory regimes, including basic Universal Illness Coverage and complements of Alsace-Moselle's regime and CAMIEG. [2]Free Medical Assistance/Departamental Medical Assistance/State Medical Aid, Complementary Universal Illness Coverage, veterans' benefits, and urgent care. [3]Prior to 1990, complementary organizations and households were recorded together.

Social Security spending is focused on assisting the individuals at highest risks and cost. Patients with chronic and long-term illnesses ("ALD" patients) represent a minor share of the population, but they receive the largest share of Social Security revenues allocated to

are: (i) hospital care; (ii) ambulatory care (doctors, dentists, medical auxiliaries, and analysis laboratories); (iii) medical transportation; (iv) drugs; and (v) other medical goods (optics, prostheses, minor equipment, and dressings). The sources of financing are divided into: (i) the public insurance scheme ("Social Security"); (ii) the State and local collectivities; (iii) complementary private insurance ("complementary organizations"); and (iv) individuals ("households").

health care. In 2015, 17% of the population was classified as ALD patients, while 62% of the health care reimbursements provided by Social Security sought to pay for the treatments associated with such conditions (Assurance Maladie, 2018).

There were also structural shifts in the private insurance sector over the past decades (Table 3.6). Two trends in private insurance stand out: the accelerated concentration of the sector, and the increasing market share of for-profit insurance companies. The number of establishments providing complementary insurance contracts halved in ten years – from about 1,631 in the mid-2000s to 825 in 2015. The space occupied by for-profit institutions (insurance companies) grew to the detriment of not-for-profit organizations (mutual companies and pension institutions), both in terms of the number of institutions in the market and the volume of contributions (insurance premiums) appropriated by them.

Table 3.6 France, complementary insurance sector, 2001 and 2015, market share indicators

	Market share (% of the number of institutions)		Market share (% of contributions)	
	2001	*2015*	*2001*	*2015*
Mutual companies	90%	77%	60%	53%
Pension institutions	3%	4%	21%	18%
Insurance companies	7%	19%	19%	29%

Source: author's elaboration based on DREES (2017b).

In contrast to public insurance, private insurance targets individuals with lower health and financial risks. In this way, even though private insurance in France is mostly complementary and not-for-profit, it can still promote discrimination among individuals and intensify inequalities. For example, the cost of premiums and the coverage provided by complementary contracts can vary according to age and occupational status. The working population usually benefits from more favorable conditions, with lower premiums and more extensive coverage. A comparative assessment of different complementary plans using data for the early 2010s showed that plans acquired as part of a working contract (collective plans) cost less and provided higher reimbursements than individual plans. The study found a 15% difference in the price of premiums for contracts with the same level of coverage. It also showed that private contracts tend to become more expensive and less supportive with age. Plans for individuals above 75 years old cost, on average, 75% more than those offered to young adults. Moreover, the share of their health expenses not covered by the insurance contract was more than double that of younger adherents (DREES cited by Cour des Comptes, 2017).

3.3. Mechanisms of financialization

We have seen elsewhere that France has gone through a relatively early process of financialization spearheaded by the State (section 1.2.2). We can argue that a similar development occurred within the Social Security system. This section examines the adoption of financialized policies in the French PHS, showing how the government rewired the system's financing circuits in ways that expanded the participation and influence of financial

capital. We develop our analysis by looking at three dimensions of financing, related to the management of long-term debts, short-term financing requirements, and hospital infrastructure. Even though part of these policies was not restricted to the financing of the PHS, targeting instead the whole system of Social Security, the former played a critical role in driving these transformations, as shown in the following.

3.3.1. Financialized strategies for long-term debt management: the Social Debt Amortization Fund

The first major policy shift in Social Security that connected it to financial capital came in the context of a new strategy for managing the system's debt. Since the mid-1990s, the long-term financing of the Social Security debt became subjected to new arrangements that rely on financial markets. These arrangements were built around the Social Debt Amortization Fund (*Caisse d'Amortissement de la Dette Sociale*, CADES). CADES is an external agency created to absorb the Social Security debt and convert it into securities that can be sold in the financial markets and repaid over the years. From 1996 to 2018, the Fund had absorbed approximately €260 billion in debts (CADES, 2018a) to be financed in such a way, accounting for around 10% of the country's GDP in this last year.[79]

Contextualizing CADES' creation

Before the creation of CADES, the Social Security debt was mostly refinanced by public institutions. The Central Agency of Social Security (ACOSS), a body created in the late 1960s to administer the system's accounts, was in charge of addressing eventual funding shortfalls and outstanding debts (see Figure 3.1). It solved these issues by appealing to cash advances from the Treasury and loans from the *Caisse des Dépôts et Consignations* (CDC), a public bank created in the early 19th century and serving multiple roles for the French public sector.

In the context of mounting deficits in Social Security during the early 1990s, ACOSS was faced with ever-larger financial imbalances. The central agency became permanently dependent on financial support from the Treasury and the *Caisse des Dépôts* to manage Social Security accounts. The recurrent deficits in the system led to a mounting debt, held by ACOSS and refinanced at high costs with the former institutions. This can be at least partly understood by the fact that, by law, the central Agency, ACOSS, can only perform short-term operations with other institutions – when financing conditions are typically less favorable. The high costs of the financial support obtained by ACOSS to refinance the Social Security debt further undermined the system's financial situation. In 1993, the amount of interest that the Central Agency paid to the Treasury and the *Caisse des Dépôts* was estimated at €1.2 billion, one-tenth of the total deficit of €12.3 billion expected for the year (CCSS, 1994). Still in 1993, the State made an exceptional move and assumed the debt of Social Security with the *Caisse des Dépôts*. The expectations for the following years were

[79] Total debt taken over (amortized and non-amortized), expressed in constant values of 2018 adjusted for inflation according to the Consumer Price Index (IPC).

of continued deficits in the Social Security accounts, aggravated by high interest charges (CCSS, 1996, 1995, 1994, 1993).[80]

The idea that the debt management policy added further pressure on Social Security accounts justified the search for alternative strategies to refinance the system's debt over a longer period of time and under more favorable conditions. This led to the creation of CADES, the Social Debt Amortization Fund. The French government instituted the Amortization Fund in 1996, amidst a major structural reform in Social Security under a right-wing majority known as the "Juppé Plan" (*Plan Juppé*).[81] One of the main goals of this plan was addressing the Social Security deficits and debt. To do so, it set up a special agency, CADES, which was in charge of writing off the Social Security debt accumulated up to that date. The agency is currently classified as a "special fund" that is part of Social Security, but financially independent from the system's regimes. It is subordinated to the joint supervision of the Ministries of the Economy, Finance and Industry, and Social Security affairs.

CADES was assigned with three missions at the time of its creation: (i) take on the Social Security debt with the *Caisse des Dépôts,* of €28 billion; (ii) reimburse the State for taking over past debts for Social Security; and (iii) cover the 1995 and 1996's deficits of the independent workers' regime that existed at that time (France, 1996).[82] CADES' creation law authorized the Fund to borrow funds from external agents in order to accomplish these goals. From the very beginning, these funds were expected to come from the financial markets. As stated in law, the agency was allowed "*(...) to take out loans. It may, in particular, to this effect, from its outset, make a public offering and issue any negotiable security representing a debt right*" (*op. cit.*, art. 5, I). Just as regular financial securities, the securities issued by CADES work as a type of loan; one party (in this case CADES) sells a note and receives funds in return, under the commitment of reimbursing the other party (in this case the investors who purchase the securities) at a later date, with added interests. These debt securities therefore provide financial gains for the lender (the investors) in the form of interest payments.

Over time, CADES' responsibilities have increased in scale and scope. Besides amortizing the Social Security debt received from other bodies of the system, its missions have broadened to include absorbing deficits of specific branches, making payments to Social Security bodies, and assisting in the financing of the Central Agency of Social Security by subscribing to its financial securities (as explained in section 3.3.2).

The creation of a public amortization fund to refinance and erase the Social Security debt can be considered a major financial innovation. To our best knowledge, no other country to date has an external agency dedicated exclusively to refinancing the Social Security debt

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[80] Values for the general regime, converted from francs to euros of 2018 according to the Consumer Price Index (IPC). As pointed out by the Social Security Audit Commission's reports at the time (CCSS, 1996, 1995, 1994, 1993), these deficits cannot be attributed solely to imbalances between Social Security's revenues and expenditures. Other factors also had an adverse impact on the systems' finances, especially the macroeconomic context and the revenue losses from tax exemptions on social contributions.
[81] Named after Alain Juppé, French Prime Minister under Jacques Chirac's first term.
[82] Values converted from francs to euros of 2018 according to the Consumer Price Index (IPC).

in the financial markets.

Deconstructing CADES' strategy

The largest part of the so-called "social debt" passed on from the Central Agency of Social Security to CADES consists in the debt of the General Regime of Social Security.[83] This debt arises from the accumulation of deficits over years. More precisely, when the total amount of revenues received by the Central Agency to finance the system in a given year is insufficient to cover all expenditures of the Social Security branches – i.e., when it faces a deficit, the agency ends with an outstanding debt in its balance sheet (see Figure 3.1). Such debt stays with the Central Agency until it is transferred to CADES. This transfer is done through an accounting move voted by the Parliament in certain years, with no defined frequency. The amounts transferred can cover past, present, and even future debts, and are decided based on the expectations for the Social Security deficit in the years to come.

When CADES was launched in 1996, it was conceived as a temporary entity responsible for settling only the debt that had been entrusted to it at the time of its creation. This was expected to be done until 2008, when it would close its activities. However, CADES' mandate has been continuously extended in light of new debt transfers. Already in 1998, the end date was postponed to 2014. In 2004, its extinction was suspended during a structural reform in Assurance Maladie. Six years later, in 2010, the government reintroduced an end date, this time to 2025. The prorogation of CADES' activities accompanied new rounds of debt transfers from other Social Security entities to the Fund, with important movements in 1996, 1998, 2004, 2009, 2011, and 2019.[84]

CADES can amortize the Social Security debt by taking it from other entities and managing it differently. On the one hand, it can refinance the debt in the medium and long run; on the other, it can raise additional sources of funds to pay for the refinancing costs. To roll the debt over a more extended period of time, CADES issues medium- and long-term debt securities in the financial markets, selling them to domestic and foreign investors. In this way, the Social Security debt is transformed into a financial debt. When the interests and the principal of such securities are paid, that debt is considered amortized. To pay for the interests and principles on the securities, the Fund receives money from public sources, mainly tax revenues collected from the population at large. It is important to note, therefore, that CADES' strategy is viable not only because it can reschedule the debt in the financial markets, but also because the government provides it with additional revenues that were not available before. These revenues are critical to pay the interest and amortizations on the

[83] Apart from the debt of the General Regime, the term "social debt" can take on other meanings. These include the debt of all mandatory basic schemes or even of the whole scope of Social Security administrations (encompassing, for example, mandatory complementary schemes and public hospitals). By the end of 2017, the debt of Social Security administrations stood at €226.1 billion, accounting for 10% of total public debt, worth €2.2 trillion. The chief drivers of the Social Security debt were, in this order, CADES (€120.8 billion of outstanding debts – i.e., still not amortized), ACOSS (€27.8 billion), Unédic, which finances unemployment insurance (€33.5 billion), and public hospitals (€29.8 billion by the end of 2016) (Cour des Comptes, 2019).
[84] Although our investigation is limited to 2018, the relevance of the 2019 debt transfer justifies its inclusion in this paragraph.

securities and, therefore, finance the continued reproduction of this strategy.

The government introduced a new social contribution in 1996 whose revenues should go directly to CADES. It also made changes in existing contributions and earmarked part of the additional revenues to the Fund. As of 2018, CADES received revenues from the following sources:

- The Contribution for the Reimbursement of the Social Debt (CRDS), integrally allocated to CADES. It is levied on a wide range of incomes from labor activity, replacement, investment, wealth, and gambling, at a rate of 0.5%;
- The General Social Contribution (CSG), partially allocated to CADES since 2009. It is levied on a similar base, at the rate that goes to the Fund has gradually increased from 0.2% in its first year to 0.6% in 2016 (the full rate – exceptions apply), and even more afterward according to government announcements;
- The Pension Reserve Fund, a public fund created to support the payment of future pension benefits, which has been obliged to transfer €2.1 billion per year to CADES since 2011;
- Revenues from the sale of public property, derived from the sale of real estate owned by national Social Security agencies. This rule was instituted in 1996 and had provided CADES with over half a billion euros by 2003.[85]

In practice, CADES is almost exclusively funded by the two social contributions in the list, the CRDS and the CSG. In 2017, these accounted for 87% of its revenues (41% and 46%, respectively). The remaining 12% came from the Pension Reserve Fund (FRR). Property sales were particularly important at the beginning but now have marginal relevance, providing around 1% of total revenues (CADES, 2017a, 2017b).

Another interesting way to examine CADES' revenues is by looking at the sources of income on which these taxes are levied. Due to the predominance of social contributions, most of these revenues derive from wages and social benefits. At present, around 60% of the Fund's revenues come from taxation on activity income (wages, agricultural profits, and other bonuses), 20% on replacement income (pensions, daily allowances, unemployment benefits, social benefits, housing subsidies), 4% on wealth, 5% on investments, and 1% on gambling and other revenues. To identify the origins of the remaining 12% coming from the Pension Reserve Fund, one has to go back to the time when the fund was set up, in 2001. The revenues used to constitute the fund came from social contributions, revenues from privatizations and public licenses, and transfers provided by the pension system, to name a few (CADES, 2017a; Mendez and Ragot, 2010).

In the 2000s, the government approved a number of rules to reinforce CADES's financial soundness. The PHS was particularly implicated in this process; in 2004, the

[85] Equal to €571 billion in real values of 2018 converted according to the Consumer Price Index (IPC). In the beginning, CADES also received taxes levied on capital income; however, the government erased this rule in 2016 and compensated the losses with an increase in the share coming from the CSG.

government decreed that any future surpluses achieved by Ameli would be allocated to the Fund (France, 2004).

CADES in numbers

The successive debt transfers to CADES led to a progressive rise in the latter's debt, mostly in the form of financial securities, as well as in the volume of revenues collected to pay for them (Table 3.7, Figure 3.2). By the end of 2018, the volume of debts transferred to CADES each year (I) accumulated to €260 billion in total (II). An additional transfer of €15 billion was already planned for the following years. From the amount of Social Security debt received by the Fund, €155 billion had been amortized by 2018 (III). This means that the principal and interests on the securities were paid, "erasing" this amount of debt from Social Security accounts. This accounted for 60% of the total debt transferred until 2018. There were €105 billion still left for amortization (IV), 40% of the total debt. To pay for such a strategy, CADES received €228 billion in revenues since 1996 (VI).

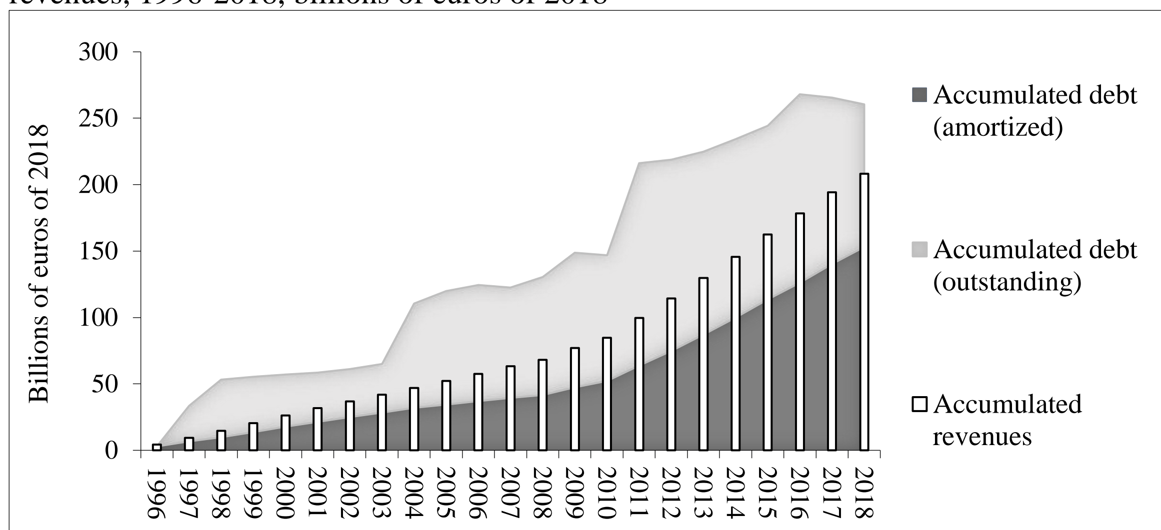
Table 3.7 France, Social Debt Amortization Fund (CADES), debt and revenues, 1996-2018, billions of euros of 2018

	Annual debt transfers (I)	Accumulated debt, total (II)	Accumulated debt, amortized (III)	Accumulated debt, non-amortized (IV)	Annual revenues (V)	Accumulated revenues (VI)
1996	28.1	31.3	2.9	-	4.3	4.3
1997	-	33.4	6.8	26.6	5.2	9.4
1998	17.5	53.2	9.9	43.2	5.3	14.7
1999	-	55.4	13.8	41.6	5.9	20.5
2000	-	57.0	17.8	39.3	6.1	26.3
2001	-	58.4	21.3	37.1	5.8	31.6
2002	-	61.1	24.9	36.2	5.8	36.9
2003	-	65.1	28.5	36.6	5.8	41.9
2004	41.9	110.6	31.9	78.7	5.9	46.9
2005	7.8	119.8	34.4	85.4	6.1	52.1
2006	6.6	124.5	37.1	87.4	6.3	57.6
2007	- 0.1	122.6	39.5	83.1	6.5	63.2
2008	11.1	130.4	41.6	88.8	6.6	68.2
2009	18.8	148.7	47.3	101.5	8.9	76.9
2010	-	146.7	52.3	94.5	8.9	84.7
2011	72.4	216.1	63.7	152.5	16.5	99.6
2012	7.0	218.9	74.9	143.9	16.8	114.4
2013	8.0	224.8	87.1	137.7	16.4	129.7
2014	10.3	234.1	99.8	134.3	16.5	145.6
2015	10.3	244.2	113.7	130.6	17.0	162.4
2016	24.3	268.1	126.2	141.8	16.3	178.4
2017	-	265.4	140.3	125.1	17.5	194.2
2018	-	260.5	153.2	107.3	17.7	208.2

Source: author's elaboration based on CADES (2018a). 1996 and 1997 figures converted from francs to euros according to the INSEE franc-euro converter. Real values of 2018 adjusted for inflation according to the Consumer Price Index. Values of accumulated debt are estimated by CADES. The decrease in total debt in 2018 is explained by the use of nominal, preliminary values.

Figure 3.2 provides a better visualization of the trends described in the table above.

Figure 3.2 France, Social Debt Amortization Fund (CADES), accumulated debt and revenues, 1996-2018, billions of euros of 2018



Source: author's elaboration based on (CADES, 2018a). CADES' estimations. Real values of 2018 adjusted for inflation according to the Consumer Price Index. Outstanding debt: total debt transferred to CADES minus the share amortized. The decrease in total debt in 2018 is explained by the use of nominal, preliminary values.

Data suggests that the Illness branch, which finances the PHS, had the highest weight in the buildup of the debt assigned to CADES. This is because this branch presents the greatest financial imbalances among the four branches of Social Security. While the reasons for them are a matter of debate and do not seem to be driven exclusively by costs (section 3.2), the fact is that those imbalanced contributed significantly to the deficits that accumulated in Social Security accounts, and therefore to the debt that was eventually transferred to CADES. Up to 2018, the weight of the Illness branch in the debt transferred to the Fund was estimated at €147.7 billion (CNAM, 2018).[86]

Instruments and costs

CADES issues several types of securities, including commercial papers (US commercial papers, USCP; Euro Commercial Papers, ECP; Negotiable European Commercial Papers, NEU CP; European Medium-Term Notes, EMTN), inflation-linked bonds, Eurobonds, and bonds in other currencies. In general, commercial papers are securities with a maturity of less than one year, medium-term notes mature from one to five years, and long-term securities (bonds), in the case of CADES, last from five to ten years. This array of securities of different durations allows the Fund to engage in short-, medium-, and long-term borrowing operations with financial investors. Besides securities, CADES also uses derivatives to hedge against the risks involved in market borrowing. In particular, it issues interest and currency swaps to hedge against the fluctuations in the value of interests

[86] Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPC).

and foreign exchange rates.[87] By 2017, the profile of CADES' operations has changed dramatically, and the vast majority of operations were now with short-term securities (commercial papers). They accounted for 81% of the securities issued this year. The remaining 19% came from the issuance of medium- and long-term securities (notes and bonds). Still in 2017, 54% of the outstanding debt (accounting for present and past issuances) was falling due in the medium-run (from one to five years), 31% in the long-run (over five years), and 15% in the short-run (one year or less). Most of the outstanding debt in this year was in Eurobonds (59%), followed by bonds in other currencies (25%), inflation-linked bonds (8%), and medium-term notes (4%) (CADES, 2017b).

Concerning the costs of this strategy, CADES' securities can be issued at fixed interest rates, variable rates, or rates indexed to inflation. Data for 2017 (CADES, 2017b; France, 2018) show that 34% of the outstanding debt in this year was remunerated at fixed rates, 28% at variable rates, and 8% at indexed rates. Since the mid-2010s, the Fund has been able to finance itself at negative interest rates. In other words, it was able to find purchasers for its securities while offering low or negative interest rates. This also means the Fund was able to make financial gains from operations that would typically incur charges for it.[88] Obtaining financing at negative rates is a recent phenomenon most typically associated with government bonds. These are considered the most liquid and safe assets in the market, which allows the government to find demand for these assets even under negative rates. CADES' securities are perceived as virtually as safe as those offered by the State, which means it was also able to find demand for its securities under the same conditions. In 2017, CADES' average interest rate was -0.65% for short-term financing and -0.17% for long-term financing. The average rate paid on the outstanding debt at the end of the year was 1.74%.[89]

CADES's securities are implicitly backed up by the State, but may offer more flexible conditions and higher interest rates for investors than those found in State securities. Although the difference in interest rates between CADES and State's securities may seem small (Assemblée Nationale, 2016), the sheer volume of funds mobilized by CADES, to the tune of billions of euros, makes this differential have a significant impact over time. Moreover, unlike the French State, CADES is authorized to operate in other currencies, which can be an advantage for foreign investors.

We can compare CADES' interest rates with those paid by the State on its securities, bearing in mind that the results must be interpreted with caution due to data constraints and differences in methodology. The interest rates offered by CADES that could be directly compared with those paid by the State are those offered at a specific point in time, once this

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[87] The principle of a rate swap is to compare a floating rate and a fixed rate, with the parties paying each other rate differentials without exchanging capital. Swaps serve as an instrument of protection (for those transferring risks from market fluctuations) and speculation (for those expecting gains from such fluctuations).

[88] Negative interest rates have been conventionally explained as an exceptional measure associated with stimulus policies carried out by central banks following the Global Financial Crisis and the Eurozone Crisis of the late 2000s. In this context, governments practiced negative basic interest rates to discourage investors from holding their capital in highly secure assets. There is much debate on why they continued to be the case for a long time and the reasons leading agents to lend at negative rates, a discussion that escapes the scope of this analysis (see, e.g., Ainger, 2019; Duarte, 2019).

[89] This rate reflects the weighted average of the interest rates offered by CADES' securities, including those issued before the interest rates became negative.

is the information available for government securities (Banque de France, 2019b). However, there is limited data on CADES' annual interest rates. Considering 2017, CADES' average interest rate for the short-term securities issued this year was -0.063%. These are negative rates, but still less punitive than those offered by Treasury bills, which ranged from -0.64% (12-month Treasury bill) to -0.85% (1-month Treasury bill). This suggests that CADES' securities were more attractive to investors. The picture is reversed when it comes to long-term financing. In the same year, the average interest rate of long-term securities issued by CADES was negative, at -0.172%. The average interest rates of Treasury bonds, on the other hand, were positive, at 0.01% for five-year bonds and 0.8% for ten-year bonds (Banque de France, 2019b; France, 2018).

This comparison becomes more difficult when trying to look at the evolution of these interest rates over time. This is because the only data series for CADES' interest rates with information for a relatively long period of time is the one for the average interest rate paid on its outstanding debt, taking into account the rates paid on securities issued in both the current and previous years (

Table 3.8). Taking into consideration that data for the State's interest rates are for a given year and not for its outstanding debt, it is still possible to observe that CADES' average financing costs tended to be higher than the costs of debt financing by the State.[90]

Table 3.8 France, Social Debt Amortization Fund (CADES) and State's interest rates, 2009-2017, %

	CADES	French Public Securities						
	Weighted average (outstanding loans)	1-month T. bill	3-month T. bill	6-month T. bill	9-month T. bill	12-month T. bill	5-year T. Bond	10-year bench-mark bond
2009	3.38%	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3.60%
2010	3.56%	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3.35%
2011	2.84%	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3.15%
2012	2.70%	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2.25%
2013	2.52%	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2.43%
2014	2.42%	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	0.84%
2015	2.08%	-0.63%	-0.45%	-0.41%	-0.38%	-0.39%	0.08%	1.00%
2016	1.61%	-1.08%	-0.90%	-0.86%	-0.81%	-0.74%	-0.13%	0.68%
2017	1.74%	-0.85%	-0.78%	-0.72%	-0.67%	-0.64%	-0.01%	0.79%

Source: author's elaboration based on Banque de France (2019b) and France (2018). Interest rates in 31/12. n.a: not available. T. bill: Treasury bill. T. bond: Treasury bonds.

The volume of revenues channeled to the banking and financial sector can be assessed by looking at CADES' financial charges (Table 3.9, Figure 3.3). These charges comprise interest payments from market operations (securities) and bank operations (loans), as well as commissions to financial institutions. From 1996 to 2018, CADES paid almost €68 billion to investors in interest payments and similar charges on financial securities (I). During the same period, it also paid an additional €3.1 billion in interest payments to credit institutions on both loans and transactions with securities (II). In total, CADES channeled €71 billion to financial actors in the form of interest payments and similar charges (III). The payment of

[90] See Crepin (2017) for a different approach reaching to a similar conclusion.

commissions (VI) added €768 million to this figure.[91] These costs are not negligible; in 2017, CADES paid €2.2 billion in interests and commissions, net of interest income. This was the same value as the so-called Social Security "deficit" of that year (CCSS, 2018).[92]

The net costs with interest payments (V) are calculated by deducting the interest income received from securities held by CADES and other types of financial revenues, such as profits from operations in foreign currencies (IV). Since 1996, the Fund made €10.7 billion in financial income. Most of it came in recent years, from the issuance of securities at negative interest rates and securities issued in foreign currencies in the context of favorable exchange rate variations. The value of financial income earned in the year almost tripled during the last decade, from €382 million in 2010 to €1 billion in 2017.

From 1996 to 2017, the amount of resources transferred from CADES to the banking and financial system, already net of financial gains, totaled €61 billion (VII).

Table 3.9 France, Social Debt Amortization Fund (CADES), interests and commissions, 1996-2018, millions of euros of 2018

	Interest charges, market operations (I)	Interest charges, bank operations (II)	Total interest charges (III = I+II)	Interest income (IV)	Net interest charges (V = III-IV)	Commissions (VI)	Net financial charges (VII = V+VI)
1996	745	685	1,430	117	1,313	79	1,392
1997	1,567	15	1,582	254	1,328	55	1,383
1998	2,198	268	2,466	270	2,195	57	2,253
1999	2,165	123	2,289	146	2,142	61	2,203
2000	2,195	150	2,345	183	2,162	10	2,171
2001	2,088	184	2,271	297	1,974	9	1,983
2002	1,857	161	2,018	241	1,777	11	1,787
2003	1,816	145	1,961	214	1,747	3	1,750
2004	2,017	188	2,205	376	1,829	30	1,860
2005	3,334	171	3,505	553	2,952	39	2,991
2006	3,507	149	3,655	606	3,049	27	3,077
2007	3,663	133	3,796	272	3,524	9	3,533
2008	3,564	210	3,775	356	3,419	10	3,430
2009	3,320	51	3,371	309	3,062	54	3,115
2010	3,636	12	3,648	382	3,266	19	3,285
2011	4,162	163	4,325	341	3,984	64	4,049
2012	4,775	60	4,835	629	4,206	58	4,263
2013	4,076	43	4,119	621	3,497	25	3,523
2014	3,951	43	3,994	668	3,327	28	3,355
2015	3,658	45	3,703	904	2,799	28	2,827
2016	3,434	42	3,476	1,118	2,359	39	2,398

(continue)

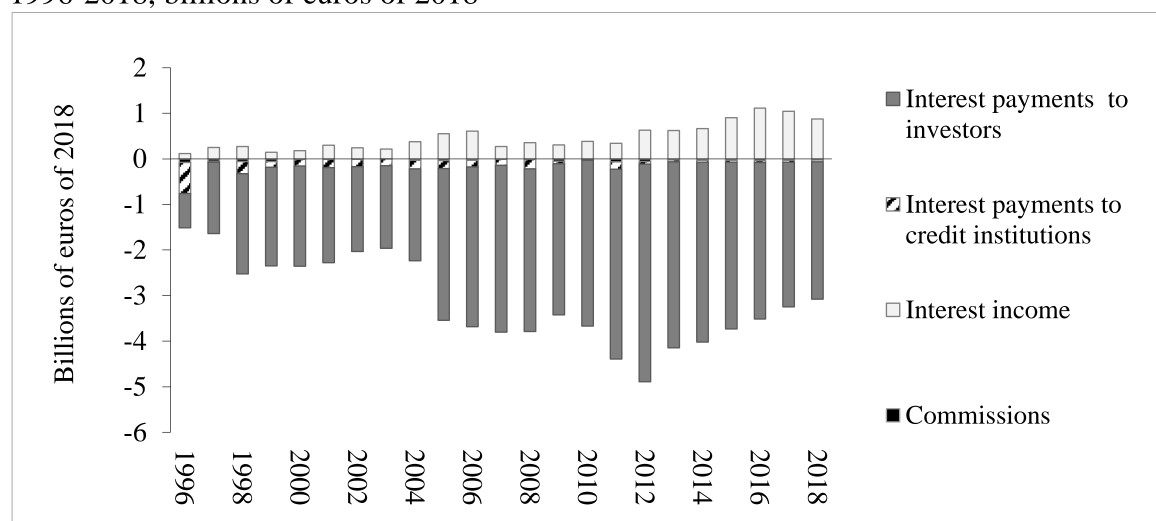
[91] Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPC).
[92] Without the Fonds de Solidarité Vieillesse (Old Age Solidarity Fund).

2017	3,171	43	3,214	1,044	2,170	32	2,202
2018	3,014	44	3,058	874.5	2,184	23	2,207
Total	67,913	3,128	71,041	10,776	60,265	768	61,037

Source: author's elaboration based on CADES (2017b, 1996-2018). Figures for 1996 and 1997 converted from francs to euros according to the INSEE Franco-Euro converter. Real values of 2018 adjusted for inflation according to the Consumer Price Index.

Figure 3.3 uses these series to provide a clearer visualization of the costs of CADES' strategy.

Figure 3.3 France, Social Debt Amortization Fund (CADES), financial results per year, 1996-2018, billions of euros of 2018



Source: author's elaboration based on (CADES, 2017b, 1996). CADES estimations. Real values of 2018 adjusted for inflation according to the Consumer Price Index.

Investors and intermediaries

Banks are the largest buyers of the CADES' securities in primary markets, followed by central banks and institutional investors (namely insurance companies and pension funds) (Table 3.10). Besides their role as investors, banks are also the most important actors in the chain of intermediation for CADES' operations. The securities are issued and distributed by private for- and not-for-profit banks, including foreign institutions. The banks responsible for placing the securities issued by CADES include private banks from Europe, United States, and Asia, such as Merrill Lynch, BNP Paribas, BRED Banque Populaire, Citigroup, Crédit Agricole, Deutsche Bank, HSBC, Natixis, Nomura, The Royal Bank of Scotland, Société Générale, and UBS (CADES, 2004, 2018b).

Table 3.10 France, Social Debt Amortization Fund (CADES), purchase of securities by type of investor, 2009-2017, % of securities issued in the year

	2009	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*
Banks	42%	34%	42%	45%	46%	25%	41%	55%	50%
Central Banks	23%	29%	29%	17%	26%	54%	41%	32%	28%
Institutional investors	35%	36%	28%	38%	29%	21%	17%	13%	21%
Others	0%	1%	1%	0%	0%	0%	0%	0%	1%

Source: author's elaboration based on CADES (2017b, 2016).

Other financial institutions also play a crucial role in the success of CADES' financing programs. These include clearing agencies, which are independent, privately-owned institutions responsible for settling these transactions. The clearing agencies working for CADES are Euroclear and Clearstream, based in Belgium and Luxembourg, respectively. Credit rating agencies are another important type of institution in the context of these operations. These are private companies in charge of assigning grades on financial instruments, signaling to investors the level of risks involved in their purchase. They are key for the success of CADES' emission programs, influencing both the volume of demand and the minimum levels of compensation that investors are willing to accept. CADES' securities are rated by Moody's, Standard & Poor's, and Fitch Ratings, the three giants of the global rating industry. The grades they assign to CADES' securities are extremely high, reflecting virtually no risk of default (CADES, 2017b).

CADES' strategy is heavily dependent on foreign capital. Most of the investors that buy the securities are based in other European countries. However, there was a marked increase in the participation of American and Asian capital over the past decade. Together, their participation in CADES' financing more than doubled in six years, from 16% of the capital raised in 2011 to nearly 35% in 2017. Asian and American investors bought 19% and 15% of the securities issued in this last year, respectively. French capital has marginal participation, at around 6% of CADES' financing in 2015 and 11% in 2016 (CADES, 2017b, 2016).

CADES issues securities in euros, US dollars, Australian dollars, Hong Kong dollars, Canadian dollars, British pounds, Japanese yens, Swiss francs, and Chinese renminbis (yuans), to cite a few.[93] The authorization to issue securities in foreign currencies and markets is specifically designed to attract foreign investors. The latter see in CADES an opportunity to profit from securities guaranteed by the French state and with additional advantages over traditional government bonds. As explained by CADES' President in 2016, foreign investors often face regulatory barriers and liquidity requirements that prevent them from freely investing in currencies other than they own. Therefore, that CADES can issue securities in other currencies makes them particularly attractive to international capital (Assemblée Nationale, 2016).

[93] In 2015, CADES issued a bond program in renminbi worth €437 million in 2018 prices. At that time, it was "*the first bond in RMB ever launched by France and the largest one in Chinese currency [issued] by an Eurozone issuer*" (CADES, 2015, p.1).

State support

CADES enjoys large State support against liquidity and solvency issues – the capacity of meeting short and long-term financial commitments, respectively. The French State is required to service the debt of national public agencies in the event of their dissolution (France, 1980), which includes that of CADES. Moreover, as determined in CADES' founding law, the French Government is required to ensure that the principal and interests are paid to investors on the expected dates:

> If the annual revenue and expenditure forecasts for the fund for the remainder of the period for which it was created show that it will not be able to meet all of its commitments, the Government shall submit to Parliament the measures necessary to ensure that the principal and interest are paid on the scheduled dates (France, 1996, art. 7).

Besides solvency and liquidity, the government also guarantees sufficient revenue streams to remunerate investors. CADES' revenues, specified earlier in this section, draw from relatively stable sources of income (e.g. wages and pension benefits). These sources of revenues are determined by the government, earmarked for the agency, and can increase upon State decision. The State's support is openly acknowledged by credit rating agencies as the primary reason for the high grades assigned to CADES' securities (see, e.g., Euromoney, 2011).

This section described the innovative way in which the French State sought to externalize the Social Security debt by transferring it to an external body so it could be transformed into assets sold in financial markets. CADES' strategy has introduced the large-scale use of financial instruments to manage the Social Security debt and opened space for a greater influence of financial institutions and investors on the system's financing conditions. In the following section, we will examine how a similar strategy was introduced ten years later for the management of short-term financing requirements.

3.3.2. Financialized strategies for short-term financing by the Central Agency of Social Security

Since the mid-2000s, the use of financial securities has spread to other areas of the Social Security system. These instruments became the central instrument not only to refinance the debt in the long run, but also to cover funding gaps in the short run. The transition from public to financial capital to address urgent cash requirements was headed by ACOSS, the Central Agency of Social Security Organizations.

Contextualizing the adoption of financialized practices by the Central Agency

ACOSS is a Social Security body created in the 1960s, during the first wave of structural reforms in the system (France, 1967). These reforms separated Social Security into branches for the first time (at the time, Illness, Old-age, and Family). They also introduced

ACOSS to serve as a "central body" that could ensure the smooth financing of the system and coordinate the distribution of resources across the newly created branches.

Over time, ACOSS' roles in the Social Security system increased in number and complexity. The agency is often described as the "central bank" of Social Security due to its critical roles to guarantee a well-functioning system. Among the most important tasks performed by ACOSS, there is, first, managing the financing of the General Regime of Social Security, centralizing revenues from different sources and distributing them across its branches (Figure 3.1). Second, it must ensure that there will be enough funds for paying the Social Security benefits, borrowing from external sources if necessary. Last, ACOSS is in charge of optimizing financial flows inside the system. This is done by lending to the different bodies that are part of Social Security, borrowing from them, and remunerating the deposits they keep with the agency, to mention a few activities. In 2017, the value of financial transactions that circulated through ACOSS' accounts amounted to €2.3 trillion, equivalent to the country's GDP in that year (ACOSS, 2018b).[94]

Financial capital entered the agency's financing circuits serving as a source of external funding (the second task mentioned above). It served to cover cash requirements, which appears when the amount of funds received by the agency from regular revenue sources is not sufficient to cover the Social Security benefits falling due in the near future (the next days or weeks).[95] This mismatch between the volume of revenues from permanent sources available at a specific date and that which is necessary to cover payments coming due is also known as "cash needs" or "Treasury needs". It is important to note that they do not necessarily mean an imbalance in Social Security accounts but may arise from the very nature of its revenues and expenditures. For example, most social contributions are collected at the end of the month, while part of social benefits (e.g., some sorts of pensions, reimbursements from Ameli, and welfare benefits) is paid earlier in the month or does not follow a fixed schedule. ACOSS can borrow from other agents to raise additional revenues and cover those funding gaps.

Historically, the agency turned toward public banks to address short-term funding requirements. Its main partner was the *Caisse des Dépôts et Consignations* (CDC), the same public bank that refinanced the Social Security debt for the agency before CADES' creation. ACOSS used short-term loans and cash advances from the *Caisse des Dépôts* to obtain the necessary financing to cover such requirements. However, the ongoing deterioration of Social Security accounts in the early 2000s turned the bank's support, in principle an exceptional measure, into an integral part of the system's day-to-day operations. They made

[94] This is possible because a single transaction can be separated into several shorter operations that can be accounted for separately. For the sake of illustration, the circuit to pay for Social Security benefits depends on monetary flows first from taxpayers to collecting agencies, from these to the Central Agency, from the latter to Social Security Funds, and finally from the Funds to individuals (see Figure 3.1).

[95] ACOSS' "regular" or "permanent" revenues are those coming from traditional sources such as social contributions, general taxation, and State transfers. They differ from "external" or "non-permanent" revenues, coming from operations with third parties (Figure 3.1). In 2017, nearly 70% of ACOSS' regular revenues came from contributions levied on wages, 17% from reimbursements (mainly State transfers to compensate for benefits paid on its behalf), 10% from other taxes allocated to the Social Security (value-added tax, behavioral taxes), 3% from contributions on replacement income, and 2% from contributions on wealth, investment, and gambling income (ACOSS, 2018a).

ACOSS ever more dependent on CDC loans and led to a growing debt with the latter.[96] As noted in the previous section, the interest rates charged by the *Caisse des Dépôts* were considered excessively high. For the sake of illustration, ACOSS paid €168 million in interest charges to the *Caisse des Dépôts* in 2003, mostly to finance short-term requirements, since CADES was already in operation to take care of long-term debts. This amounted to more than 10% of the General Regime's deficit in that year (CCSS, 2004).[97]

In 2004, the *Caisse des Dépôts* denied the full coverage of Social Security's cash requirements due to the expectations that the latter's accounts would continue to deteriorate in the following months. The period was marked by intense debates, disputes, and the resort to temporary solutions to finance ACOSS' short-term needs (CCSS 2006, 2005, 2004). Amidst a context of uncertainty concerning the government's disposition to rescue the agency, the *Caisse des Dépôts*' unwillingness to fully cover the demand for funds, and the agency's desire to find cheaper financing solutions than those proposed by the bank, the proposal of "diversifying" ACOSS' revenue sources gained increasing support. This paved the way for the deployment of new strategies geared toward financial markets. Starting in the mid-2000s, the introduction of practices much similar to those adopted by CADES led to a progressive shift in the nature of the creditors covering the agency's short-term needs.

In 2006, the State altered ACOSS' legal framework to authorize it to issue commercial papers in domestic markets (France, 2008). Later in the same year, the agency launched its first commercial paper program to complement the financial support from the *Caisse des Dépôts*. in 2010, The government expanded the array of financial instruments available to ACOSS by allowing the agency to issue commercial papers in international markets (2010 Interministerial Directive, cited in France, 2014). In the same year, the role of the *Caisse des Dépôts* as the lender of last resort to Social Security underwent a major overhaul; a new convention signed between the Central Agency and the bank this year limited the aid from the CDC to one-third of the maximum amount that ACOSS was authorized to borrow each year, a value decided by the Parliament (ACOSS, 2011). In this way, it turned the bank into a supporting mechanism for market-based financing.

ACOSS currently has two instruments for meeting cash requirements: loans from the *Caisse des Dépôts*, and financial securities. The possibilities to borrow from the *Caisse des Dépôts* are restricted to a few credit lines with pre-defined interest rates. Market financing is much more flexible. ACOSS issues short-term securities, borrowing from investors in money markets – the segment of financial markets dedicated to highly liquid assets. The agency issues commercial papers, more precisely Negotiable European commercial papers (NEU CPs) in France and Euro Commercial papers (ECPs) in foreign markets. ACOSS can also use derivative contracts (namely interest and currency swaps) to hedge against the risks involved in those operations. To a lesser extent, other agents apart from financial investors can also subscribe to ACOSS' securities and thereby provide funds to the agency, including the State (the central government), Social Security administrations, and the Social Debt

[96] The imbalances in ACOSS' accounts at this time could be attributed, on the one hand, to the mismatch between revenues and expenditures in the General Regime, and, on the other, to systematic delays in State transfers to compensate for tax exemptions and payments made on its behalf (CCSS, 2003).
[97] Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPC).

Amortization Fund (CADES).

Each financing method compensates creditors and intermediaries in a specific way. CDC loans entail the payment of interests and commissions to the bank. Debt securities, in turn, require the payment of interest to investors. The intermediaries (banks) can make profits by placing and trading these instruments. The Central Agency does not specify the sources of funds used to pay for the interests on the securities (see, e.g. ACOSS, 2019b).

Besides covering short-term financing requirements, financial capital also became central for ACOSS to refinance its debt. When the agency's total expenditures exceed its revenues after the year-end, this leads to a debt that remains in ACOSS' balance sheet until being transferred to CADES. This debt also started being refinanced through securities.[98] Even the traditional relations between the Central Agency and the *Caisse des Dépôts* were reorganized due to the use of securities, as part of the bank's lending to Social Security now occurs through the exchange of such instruments. In the case of short-term loans to pay for pension benefits, for example, the bank now grants these loans via sale and repurchase agreements ("repos"), operations in which the borrower sells a security for the lender in exchange for funds under the commitment to buy it back at a higher price. In a similar vein, the use of financial securities shaped the way in which the agency finances other public and Social Security bodies. For example, these bodies can now place their financial surpluses in ACOSS or borrow funds from it using securities and repos.

ACOSS' financing strategy in numbers

Data show a structural shift in the sources of additional capital for ACOSS over the 2010s decade, from public banks to financial markets (Table 3.11,

Figure 3.4). Until the mid-2000s, the cash requirements of Social Security were almost entirely covered by loans, mainly from the Caisse des Dépôts. Their participation went from virtually 100% of external borrowing in 2004 to 3% in 2018.[99] By the late 2010s, these requirements were almost entirely covered by financial securities. They went from having no participation in 2006 to 93% of external financing in 2018. It is worth mentioning that the largest share comes of these revenues comes from securities issued in foreign markets, revealing that the new strategy is primarily based on international capital. In 2018, international securities (ECPs) accounted for nearly 80% of the Central Agency's external borrowing. Apart from securities and loans, there are also funds coming from deposits of "social partners" in ACOSS (e.g., CADES and social funds – see footnote 68). These deposits have marginal participation, at around 4% in 2018.

The total value of commercial papers issued by the Central Agency increased each

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[98] ACOSS' deficits are closely related but not equal to the so-called "Social Security deficit". ACOSS manages the revenues and expenditures of the General Regime, whose difference accounts for most of the Social Security deficit. Nonetheless, the agency also manages other revenues and expenditures. For example, it makes payments on behalf of entities other than the Social Security Funds and engages in operations with bodies outside the scope of Social Security schemes.

[99] The data for the relative participation in total borrowing reported by the agency and systematized here is based on the average values of external borrowing at different times of the year.

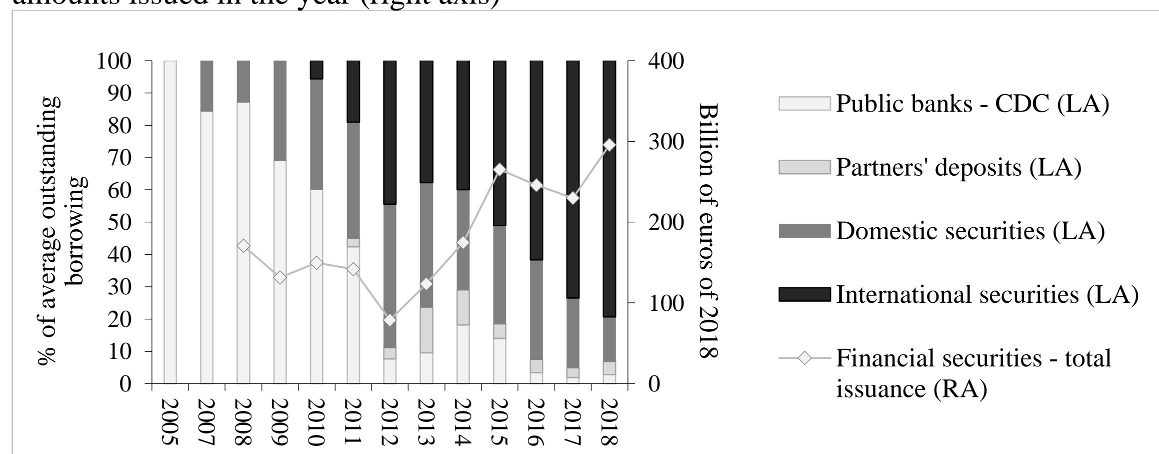
year except for 2011, reaching outstanding values at the end of the series. In total, the agency issued €2 trillion in securities between 2007 and 2018.[100] In this last year, the value of emissions reached nearly €300 billion, consolidating ACOSS' position as one of the world's largest issuers of ECPs. In 2016 and 2017, the agency was the second largest issuer of ECPs in the world, and the largest one among public entities (ACOSS, 2017a).

Table 3.11 France, Central Agency of Social Security Organizations (ACOSS), external financing by instrument, 2004-2018, billions of euros of 2018 and share in total financing

	2004	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*
Financial securities, amounts issued (billions of euros of 2018)													
Total	0	n.a	171	131	150	142	79	124	175	265	246	230	296
Domestic securities	*0*	*n.a.*	*171*	*131*	*137*	*129*	*49*	*89*	*132*	*201*	*147*	*141*	*148*
International securities	*0*	*n.a.*	*0*	*0*	*12*	*13*	*29*	*34*	*43*	*64*	*99*	*89*	*148*
Share in total financing (%)													
CDC loans	100	84	87	69	60	42	8	10	18	14	3	2	3
Partner's deposits	0	0	0	0	0	3	3	14	11	5	4	3	4
Domestic securities	0	16	13	31	34	36	44	39	31	30	31	22	14
International securities	0	0	0	0	6	19	44	38	40	51	62	74	79

Source: author's elaboration based on ACOSS (2007-2019a, 2007-2019b) and France (2018). Share in total financing based on average amounts borrowed per instrument over the year. Real values of 2018 adjusted for inflation according to the Consumer Price Index. Divergences in the total may appear as a result of approximations. Domestic securities: CPs/NEU CPs. Foreign-market securities: ECPs. n.a.: not available.

Figure 3.4 France, Central Agency of Social Security Organizations (ACOSS), financial securities, 2004-2018, participation in total short-term borrowing (left axis) and total amounts issued in the year (right axis)



Source: author's elaboration based on ACOSS (2007-2019a, 2007-2019b) and France (2018). LA: left axis. RA: right axis. Share in total financing based on average amounts borrowed per instrument over the year. Real values of 2018 adjusted for inflation according to the Consumer Price Index.

Instruments and costs

Similar to what has been observed for long-term financing, the policy changes

[100] As ACOSS can only borrow in the short run, its securities are continually maturing, and new ones are issued in their place. The high turnover makes the total value of emissions exceeds that of financing requirements, which helps explaining these outstanding values, above the actual value of cash requirements in a given year.

allowing the Central Agency to issue securities have transformed financial capital into the primary source of funds for short-term financing. As in the case of CADES, ACOSS issues securities in several currencies and works with different types of interest rates. A closer look at its 2017 financing program reveals a predominance of securities issued in foreign markets, mostly at fixed interest rates, and with a period until repayment ranging from a few weeks up to three months (ACOSS, 2018a; France, 2018).

The agency's interest rates followed a downward trend in the long run, from 4% in 2007 to -0.65% in 2017 (Table 3.12).[101] More than falling interest rates, ACOSS was able to finance itself at negative interest rates after 2015. We can put the evolution of these rates into perspective by placing them alongside the reference rate for short-term markets and those offered by State bills (short-term securities) in the same period. A common way to compare the evolution of ACOSS' interest rates relative to other market rates is by observing their spread against the Euro Overnight Index Average (Eonia), the overnight interbank lending rate in the European Union and the reference rate for short-term borrowing. On average, ACOSS' financing costs had a small spread against the Eonia up to 2015 and fell below this rate afterwards.

That the securities issued by the Central Agency are considered virtually as safe as those offered by the State is an important factor explaining why ACOSS, like CADS, can borrow at low or negative interest rates. Furthermore, ACOSS' capacity to finance itself at low interest rates in recent years, even below the interbank rate, is also strongly related to the fact that it can operate in foreign currencies. This allows the agency to strategically place securities where it can explore exchange rate differentials in its favor, paying interest rates that, when converted to euros, end up being lower than the interest rates paid in domestic currency (IGAS, 2018).

Comparisons between ACOSS and the Treasury's interest rates must be made with caution, due to methodological differences in how they are calculated. But the figures can still give an idea of how the agency's financing costs stand in relation to those of the debt that is directly financed by the State. In the last years of the series, ACOSS' rates were relatively more advantageous for investors ("less negative") than those offered by the State.

[101] Average financing rate – i.e., the average interest rate of each type of instrument, weighted by the volume of funds borrowed through each one. The available series do not allow to exclude interests on CDC loans, but these have a marginal weight in the average considering their low participation in external financing today.

Table 3.12 France, ACOSS and State interest rates, annual average, 2007-2017, %

	ACOSS		State securities							
	Average financing rate	Average cost of financing	1-month bill	3-month bill	6-month bill	9-month bill	12-month bill	2-year bond	5-year bond	10-year benchmark bond
2007	4.04	Eonia + 0.141	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	4.30
2008	3.87	Eonia + 0.044	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	4.24
2009	0.78	Eonia + 0.136	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3.65
2010	0.96	Eonia + 0.506	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3.11
2011	0.98	Eonia + 0.197	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	3.31
2012	0.18	Eonia + 0.016	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2.54
2013	0.14	Eonia + 0.043	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2.21
2014	0.20	Eonia + 0.104	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	1.66
2015	-0.06	Eonia + 0.045	-0.22	-0.20	-0.20	-0.20	-0.20	-0.18	0.14	0.85
2016	-0.45	Eonia - 0.139	-0.58	-0.56	-0.55	-0.55	-0.54	-0.52	-0.23	0.46
2017	-0.65	Eonia - 0.293	-0.67	-0.64	-0.63	-0.61	-0.58	-0.50	-0.05	0.81

Source: author's elaboration based on Banque de France (2019b) and France (2018). For State interest rates, annual average. T. bill: Treasury bill. T. bond: Treasury bond. n.a.: not available. Eonia: Euro Overnight Index Average, the overnight interbank lending rate in the European Union.

The values of financial charges paid by ACOSS indicate how much the agency channels in revenues to the banking and financial sector each year Table 3.13, Figure 3.5). Financial charges include interest payments and other costs, namely commissions and guarantees. From 2009 to 2018, ACOSS paid €496 million in charges derived from banking operations (primarily with the *Caisse des Dépôts* and the French Central Bank) and €341 million to financial markets, totaling €837 million in ten years. There was a marked decrease in financial expenditures, particularly until 2012. The primary explanation for this decrease lies in the lower interest rates paid on securities compared with those charged by the *Caisse des Dépôts*.[102] This can be observed by the decline in banking expenditures along with a less than proportionate increase in financial market expenditures. It is important to remind that such a drop in financing costs should be attributed not simply to the use of securities, but also to the fact that this transition accompanied a period of generalized fall in interest rates in the European Union.

Another important trend of the past decade was the increase in financial income. This originates from different sources. One is the interest income from ACOSS' positive accounts at the *Caisse des Dépôts* and the French Central Bank. Another is the profits made by the agency from operations with securities and derivatives. There was a sharp increase in the volumes of interest income earned by the Central Agency when it began selling securities at negative interest rates (see the discussion for CADES). The financial income from market operations amounted to €536 million from 2009 to 2018, coming mostly in the last three years of the series. Banking operations, in turn, provided €25 million, all until 2014. In total, the Central Agency of Social Security reaped €561 million in financial income in this period.

Besides interest payments, the greater complexity of the current financing strategy also brought other kinds of revenues and expenditures. For example, ACOSS made

[102] For the sake of comparison, in 2016, ACOSS' average cost of financing stood at -0.45%. Breaking it down by instrument, the average was of -0.22% for NEU CPs issued at variable rates, -0.29% for NEU CPs at fixed rates, -0.47% for ECPs, +0,005% for partner's deposits, and +0.14% for CDC loans (ACOSS, 2017b).

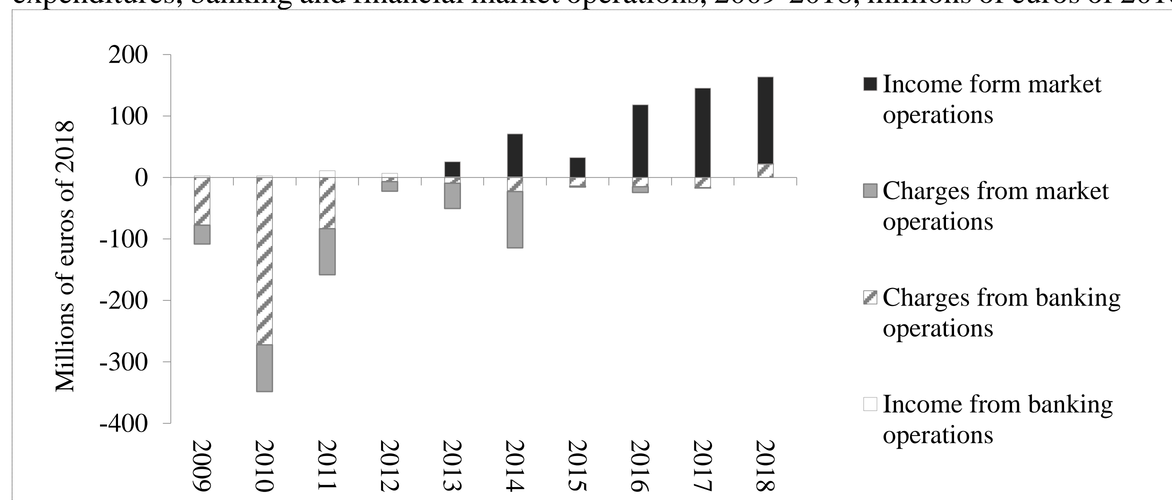
€2.2 million in profits from interest rate swap operations in 2016 – a sound illustration of the incorporation of interests and practices typical of financial institutions within Social Security agencies.

Table 3.13 France, Central Agency of Social Security Organizations, revenues and expenditures, banking and financial market operations, 2009-2018, millions of euros of 2018

	2009	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*	Total
Financial charges	108	348	158	22	50	115	15	25	17	22	837
Banking operations	*78*	*273*	*83*	*6*	*10*	*23*	*14*	*15*	*16*	*22*	*496*
Financial markets	*30*	*76*	*75*	*16*	*41*	*92*	*1*	*10*	*1*	*0*	*341*
Financial income	2	3	12	8	27	72	32	118	145	141	561
Banking operations	*2*	*3*	*11*	*7*	*1*	*1*	*0*	*0*	*0*	*0*	*25*
Financial markets	*0*	*0*	*0*	*1*	*26*	*71*	*32*	*118*	*145*	*141*	*536*

Source: author's elaboration based on ACOSS (2009-2018). Real values of 2018 adjusted for inflation according to the Consumer Price Index. Rounded values.

Figure 3.5 France, Central Agency of Social Security Organizations, revenues and expenditures, banking and financial market operations, 2009-2018, millions of euros of 2018



Source: author's elaboration based on ACOSS Combined Accounts (ACOSS, 2009-2018). Real values of 2018 adjusted for inflation according to the Consumer Price Index.

Investors and intermediaries

Much like in the case of CADES, ACOSS' market-based strategy depends on a vast array of investors and financial institutions. In the case of investors, the agency does not provide detailed information on the nature of agents which buy its securities. The possibility of knowing the investors' identities is further limited by the speed and non-disclosure of transactions in short-term markets, as well as by exchanges in secondary markets. What we know is that the agency operates in money markets, whose key participants include governments, central banks, private and public banks, mutual funds, insurance companies, non-banking financial institutions, and private companies.

Besides investors, the strategy also relies on a large chain of intermediation. The central actors in this chain are banks, both national and foreign. They organize the issuance

programs, ensure that legal requirements are met, and find investors, among other roles. The intermediaries include both French and foreign banks, mostly private; the official arranger of ECPs programs in 2018, for example, was UBS (private, headquartered in Switzerland), the domiciliary agent was Citibank (private, headquartered in the United States), and dealers included Bank of America, Merrill Lynch, Barclays, Crédit Agricole, Credit Suisse, Royal Bank of Scotland, UBS, and BRED (private and cooperative banks, headquartered in Europe and the United States). Along the same lines of CADES' instruments, ACOSS' securities flow through clearing houses based in Belgium and Luxembourg, and are evaluated by the three giants of the rating industry. The credit rating agencies classify them as extremely safe investments (ACOSS, 2019b, 2018c).

As previously noted, ACOSS' financing strategy is heavily geared toward attracting foreign capital. Most of its international securities (ECPs) are denominated in US dollars and British pounds, corresponding to 67% and 29% of ECP financing in 2017, respectively. The agency also issues ECPs in other currencies, such as Australian dollars, New Zealand dollars, Canadian dollars, and Polish zlotys (ACOSS, 2018a). Several factors explain the increasing focus on foreign markets. On the one hand, there is a high demand for ACOSS' securities from international investors. This is expected as the latter offers similar returns while also having more flexible conditions than French sovereign bonds, such as the option of having the assets denominated in foreign currency. On the other, for Social Security, foreign markets offer the possibility of increasing the supply of capital and reducing the costs of financing by exploring exchange rate differentials. Such developments have already been noted for CADES and are reinforced by statements and reports describing ACOSS' strategy (e.g., Assemblée Nationale, 2018; IGAS, 2018).

State support

ACOSS' securities are implicitly guaranteed by the State and enjoy the same level of creditworthiness assigned to government bonds. Both ACOSS and the rating agencies emphasize the French government's commitment to mitigate and withdraw any risks associated with the securities. The guarantee that the State will protect investors in case of liquidity or solvency problems is clearly stated in ACOSS' issuance programs:

> Should a court order the Issuer to pay any amounts, Law No. 80-539 (…) provides that the Minister in charge of Social Security (…) **may be required to order the Issuer [ACOSS] to pay and, if necessary, the Minister shall find the necessary resources to meet such liability and/or budget for such amounts due** in the accounts of the Issuer. Since ACOSS is a national administrative entity, the State, by way of a decision by the Minister in charge of the Economy, may subscribe for its negotiable debt instruments (ACOSS, 2018d, p. 9, emphasis added).

The same rationale is accepted by credit rating agencies. As stated in Fitch Ratings' credit report, State support is the main reason for the high grades assigned to the securities. The institution emphasizes that "*although the French government has no legal obligation to prevent a default (...) it has a strong incentive to do so and that it has the legal means to*

enable ACOSS to meet its debt service obligations in a timely manner" (Fitch Ratings, 2017, p. 1).

This section described how internal bodies of the French Social Security system, responsible for administering the financing of the PHS, began embracing financialized strategies to raise funds in domestic and foreign markets. Such a shift followed a path much similar to that which had already been traced by the body responsible for restructuring the Social Security debt. State decisions to facilitate the turn toward markets found a particularly favorable context in the 2000s, when the proliferation of financial instruments available for Social Security met a large number of investors eager to lend to the system. While the policy changes discussed so far have dealt with changes at the level of Social Security more broadly, the last section examines the advance of financialized policies specifically aimed at changing the way public hospitals are financed.

3.3.3. Government policies toward hospitals: credit-based investment programs

The expansion of the financial sector in the past decades also altered the State's approach to financing public hospitals. Since the 2000s, a government-sponsored strategy increased the participation of banks and investors in the financing of public hospital infrastructure. As of 2017, public hospital debt amounted to approximately €30 billion, of which 90% were in bank loans and 10% in debt securities (AP-HP, 2018a). The following sections briefly characterize the public hospital sector in France and then examine the programs leading it to turn to banks and financial markets.

The French hospital sector at a glance

The hospital sector in France comprises public, private not-for-profit, and private for-profit health establishments. Most hospital care is provided by the public sector, responsible for 62% of hospital beds in 2016. The remaining share is divided into 24% in private for-profit establishments and 14% in not-for-profit ones. The hospital sector lost 64,000 full-time beds from 2003 to 2016, ending this period with 404,000 full-time beds; this loss was partially offset by the creation of 25,000 part-time beds, for a total of 75,000 part-time beds in 2016 (DREES, 2018b).[103]

Public hospitals are part of the Social Security system but do not belong to any specific regime of Social Security. While public hospital budgets are formally independent of the Social Security budget, most of their revenues come from the latter in the form of compensation for services rendered to beneficiaries and other kinds of monetary transfers. These revenues derive, more specifically, from the Illness branches of the Social Security Regimes, which together make up what is known as Ameli, the French PHS.[104]

The hospital sector encompasses different types of units including hospital centers,

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[103] Official figures comprise metropolitan and overseas territories.

[104] As a reminder, our discussions in the previous sections focused on the Illness branch of the General Regime of Social Security only.

regional and university hospital centers, specialized hospital centers, and long-term care facilities. Each segment has particular trajectories and features. Regarding investment funding, the object of this section, historical records suggest that the early stages of hospital building and expansion were typically financed through a mix of self-funding, State resources, and external borrowing, at different ratios depending on the type of establishment. The State played a central role in the construction of hospitals, especially when it comes to large-scale establishments. This is best exemplified by looking at the case of regional and university hospital centers. These are a central pillar of hospital care in France, providing almost one-third of beds in the public sector and leading hospital teaching, research, and innovation (DREES, 2018b). Regional and university centers were mostly built during the 20th century, largely financed with interest-free State funds (Debeaupuis, 2004; Garnier, 2015). Their expansion and renovation in recent decades, by contrast, have relied on interest-bearing capital provided by commercial banks and financial markets.

Bringing hospitals and banks closer together: a new approach to finance investments

Bank credit gained increasing participation in public hospital financing during the 2000s decade. This was mainly the result of two five-year government programs aimed at restructuring the public hospital sector, the first launched in 2002 (the 2007 Hospital Plan, or *Plan Hôpital 2007*) and the second in 2007 (the 2012 Hospital Plan, or *Plan Hôpital 2012*). One of the primary goals of these programs was to upgrade public health infrastructure, modernizing and expanding the public hospital complex. Such tasks required massive amounts of investments. The possibility of financing such investments through State funding was constrained by several measures to contain public spending in general and health care spending in particular (section 3.1.2). In this context of fiscal austerity, the French government sought to boost public hospital investment by providing incentives to hospitals so they could borrow from financial institutions. These incentives consisted mainly of regulatory shifts that made it easier for public hospitals to obtain loans and provided subsidies to help them pay the interests and amortizations.

The Hospital Plan approved in 2002 set a target of increasing public hospitals' investment by 30% in five years (2003-2007) (France, 2003). To put the plan into action, the government announced it would provide €7.5 billion in grants to public hospitals in order to help them finance investment projects. The financial aid from the government came gradually and in two main forms. The first one was via capital grants from the "Fund for the Modernization of Public and Private Health Facilities" (FMESPP), a fund sourced from revenues of the PHS (Ameli). These grants amounted to €1.9 billion. The second and most relevant one consisted of subventions to hospitals, at approximately €536 million per year. This was done by increasing the value of regular transfers from Ameli to the hospitals, a measure that was explicitly geared toward encouraging them to take out loans (since they would have more money to pay them off). Throughout the course of the plan, the government had to provide a greater volume of funds than was originally planned, as the debt charges

were increasing above initial expectations (Cour des Comptes, 2014).[105]

Regulatory shifts also gave a major boost to public hospital borrowing. The simplification of public hospitals' legal framework in 2005 (France, 2005) was particularly important for the credit boom observed in the following years. Among several measures that facilitated public hospitals to obtain bank loans, the new legislation eliminated the need for prior authorization from a supervisory body before taking credit. Facing lower regulatory constraints, hospitals began borrowing at a much faster pace in the following years (Cour des Comptes, 2014).

As the 2002 five-year plan came to an end, the government renewed the strategy in 2007 to continue the previous strategy for another five years (France, 2007). The goal of the new plan was to increase investments in the public hospital sector by another €11.4 billion, half of which (€5.7 billion) financed by the public sector, especially in the form of subventions from Ameli to facilitate loan repayments.[106]

At first, these programs were successful in boosting public hospital investment (Table 3.14). The investments carried by these hospitals almost doubled in six years, from €4.4 billion in 2003 to €7.4 billion in 2009. The share of hospital revenues allocated to investments (the "investment effort") rose from 7.9% in 2003 to almost 11% in 2009. In the 2010s decade, however, investments began to decelerate amidst a context of crisis and over-indebtedness. The investment effort decreased continuously to reach 5.2% of revenues in 2018. Public hospital investments amounted to €3.7 billion in that year – adjusted for inflation, this was less than the value observed at the beginning of the strategy.

The investment boom was accompanied by a major increase in credit borrowing and indebtedness. Different from investments, these did not decelerate in the transition for the 2010s decade. The public hospital debt more than doubled during the first decade of the plan, from €11.9 billion in 2003 to €24.2 billion in 2009. In relative terms, the indebtedness ratio (the volume of debts in relation to hospitals' "stable resources", comprising equity and financial liabilities) rose from 33% to 46%. While investments declined during the 2010s, debt levels continued to rise. The total debt of public hospitals peaked in 2016, at €30.8 billion, and ended the series at €29.4 billion in 2018 (Cour des Comptes, 2014; DREES, 2019c).[107]

The relatively high costs of debt, coupled with the financial practices adopted by the banks (discussed below) and the insufficient rise in hospital revenues to cover the costs of the loans, contributed to a generalized over-indebtedness crisis in the public hospital sector at the beginning of the 2010s. In 2015, around one-third of public health establishments were considered to be in a critical situation, considered "excessively indebted".[108] The average

[105] Real values of 2018 adjusted for inflation according to the Consumer Price Index.
[106] Real values of 2018 adjusted for inflation according to the Consumer Price Index.
[107] Real values of 2018 adjusted for inflation according to the Consumer Price Index.
[108] In 2011, the government established a set of criteria to consider whether or not a hospital was "excessively indebted", which could help them obtain government support. The institution should meet least two of the following situations: (i) a financial independence ratio (the ratio between its long-term debt and permanent capital) of more than 50%; (ii) an "apparent duration of the debt" exceeding 10 years; and (iii) a ratio of outstanding debt to total income over 30%.

length of public hospital debt was of 13 years in the mid-2000s and stabilized at an average range from sixteen to eighteen years from then on, although some contracts extend for over forty years (Finance Active, 2016).[109]

Table 3.14 France, public hospital sector, investment and debt indicators, 2003, 2009-2018

	2003	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*
Investment effort[1] (%)	7.9	10.9	10.2	9.4	8.8	7.6	7.1	6.6	5.9	5.7	5.2
Indebtedness ratio[2] (%)	33.1	46.0	47.4	48.7	49.6	49.8	50.0	50.5	51.5	51.6	51.6
Investments[3] (€ billion of 2018)	4.4	7.4	n.a.	n.a.	n.a.	5.2	5.0	4.5	4.2	4.1	3.7
Outstanding debt (€ billion of 2018)	11.9	24.2	26.3	28.1	29.4	30.2	30.2	30.6	30.8	30.4	29.4

Source: author's elaboration based on DREES (2010-2014, 2015-2019) and Cour des Comptes (2014). Data for 2003-2017 in real values of 2018 adjusted for inflation according to the Consumer Price Index. n.a.: non-available. [1]Investment spending relative to revenues. [2]Share of outstanding debts relative to stable resources (equity, provisions, and debts). [3]DREES does not publish the absolute value of investments for the period before 2013; the figures for 2003 and 2009 derive from Cour des Comptes (2014).

Delving into the credit-based financing strategy

The business of lending to public hospitals was controlled by a few banks. The main creditors were private banks, both for-profit and cooperative (formally non-profit) institutions. As of 2010, the lion's share of hospital debt was in the hands of five institutions: Dexia (32.3%), Caisse d'Épargne (15%), Crédit Agricole (12.2%), Société Générale (9.9%), and Crédit Foncier de France (8.7%) (Cour des Comptes, 2014). The financial crisis of 2008, coupled with a looming debt crisis in the public hospital sector in the same period in light of the increasing burden of debt service costs, led traditional lenders to refrain from continuing to provide credit to these establishments. Public financial institutions had to step in to avoid the drying up of hospital financing, which would worsen the latter's already critical situation (Cour des Comptes, 2018, 2014). Despite the greater participation of public institutions in the 2010s, the largest share of public hospital debt remained in the hands of private banks (Finance Active, 2016). The greatest lender was Dexia, which made massive profits lending to the French public sector in the 2000s; in the aftermath of the 2008 crisis, the bank was bailed out by the French State, at a cost of over six billion euros (Financial Times, 2013).

Among the features of the private banking sector that contributed to the financing-cum-indebtedness *boom*, we can mention the use of financial innovations to provide credit and the adoption of aggressive marketing strategies to push them onto hospitals. This is particularly the case of the so-called "structured loans", an important financial innovation that exploded in the 2000s. Part of them became known as "toxic loans" after the 2008 financial crisis. These loans contrasted with regular ones by applying different financing conditions over the duration of the contract. These conditions were extremely appealing at the beginning of the contract, such as a long grace period and zero or low interest rates on the first installments. However, they could be significantly revised at a later stage, imposing

[109] The scope of Finance Active's survey is based on a set of approximately 400 public health institutions, representing more than three-quarters of the sector's debt.

a significant burden on the debtor. The terms of structured loans were determined according to complex regulations and calculation formulas, making them more risky and opaque than ordinary loans. Official reports and statements from professionals working in the financial industry at the time consider structured loans as one of the main causes of the over-indebtedness problems faced by several hospitals, including due to hospital managers' difficulties in properly assessing the long-term costs of such loans (Assemblée Nationale, 2015; Cour des Comptes, 2018).

Banks had a sound marketing strategy for distributing structured loans to hospitals in the context of government-sponsored investment plans. This was described by the director of a fintech company as follows:

> (…) the market was guided by banks – some of which had teams of more than 300 sales representatives – and throughout the day, financial managers from local governments and public health institutions were called upon to engage in this type of product. (…) The market was perfectly organized by the banks at the time: Dexia in the lead, Caisse d'Épargne, Crédit Agricole, Royal Bank of Scotland, etc (Assemblée Nationale, 2015).

The spread of toxic loans within the hospital sector can be assessed through the "Gissler scale", an analysis grid that allows assessing the risk levels associated with a structured product.[110] Using this scale as a parameter, data suggest that, in 2012, approximately €2.6 billion, or 10% of the public hospital debt, consisted of "extremely risky" loans. From this total, around €1.5 billion, almost 4% of the debt, consisted of "toxic loans", whose risks cannot be assessed.[111] Dexia, the largest lender to public hospitals in the 2000s, was responsible for 70% of the toxic debt held by these institutions by 2012. Public banks, in turn, did not engage in this type of practice (Cour des Comptes 2018).

The debt-based strategy brought significant costs to public hospitals in the form of interest payments. The average interest rate charged by banks remained above 3% per year, peaking at 4.08% just before the financial crisis. The costs of the bank-based strategy seem particularly high when contrasting the interest rates paid by public hospitals on their loans with those paid by the State on Treasury bonds (Table 3.15). During the 2010s, the trajectory of interest rates charged to hospitals declined at a much slower pace than other interest rates in the European Union and the rate paid by government bonds. As can be apprehended from the table, the spread against the rates of government bonds has widened over the years. This rigidity suggests that bank financing became increasingly expensive compared to direct government funding. The same caveats regarding differences in methodology made earlier apply here; still, in 2017, the average interest rate of public hospital debt stood at 2.93% per year, while the interest rate on the French State's benchmark bond (10-year *emprunt phare*)

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[110] The Gissler charter evaluates the "quality" of the loan considering the complexity of the underlying index and the formula used to calculate the loan's interest rate. The grades can vary from A to F. Loans graded as D, E, and F are considered extremely risky. Those classified as 6F or "out of the charter" are the so-called "toxic loans", whose risks cannot be assessed (Cour des Comptes, 2018).

[111] Real values of 2018 adjusted for inflation according to the Consumer Price Index.

closed the year at 0.79%.

Table 3.15 France, interest rates of public hospital debt and Treasury bonds, 2005-2018, %

	Public hospitals, average interest rates of outstanding debt[1]	French securities, interest rates of 10-year Treasury bond
2005	3.67%	3.29%
2006	4.00%	3.98%
2007	4.08%	4.42%
2008	3.84%	3.41%
2009	3.25%	3.60%
2010	3.31%	3.35%
2011	3.50%	3.15%
2012	3.35%	2.25%
2013	3.43%	2.43%
2014	3.36%	0.84%
2015	3.26%	1.00%
2016	n.a.	0.68%
2017	2.93%	0.79%

Source: author's elaboration based on Finance Active (2016) and Banque de France (2019b). Values of December 31. [1]Data for approximately 400 health care establishments covering over three-quarters of public hospital debt. n.a.: not available.

Public hospitals service their debts out of their revenues. As previously noted, the largest share of hospital revenues comes from the PHS (Ameli). Over the last decade, the revenues received from the public system accounted for nearly 80% of their revenues – 78% on average between 2010-2018 (DREES 2010-2014, 2015-2019).[112] Therefore, one might infer that most of the funds used to pay interests to banks were ultimately provided by Social Security.

The decline in investments along with mounting debts suggests that an increasingly larger share of revenues was drifting away from the expansion of public infrastructure to debt repayments. The evolution of the sector's financial results (Figure 3.6) corroborates this view. Financial results correspond to the difference between public hospitals' revenues and expenses related to debt and investments. Therefore, a negative result reflects the amount of financial charges paid by hospitals, already discounted of any financial income they might receive. We could therefore consider it a suitable indicator to assess the costs of financial operations. Data show that the volume of financial charges, net of income, doubled from around €500 million per year at the beginning of the 2000s to approximately €1 billion per year by the late 2010s. These values appear in the figure below as negative financial results. Summing up all values for the period 2002-2018, we find that hospitals paid €13.7 billion in financial charges, net of financial income.[113]

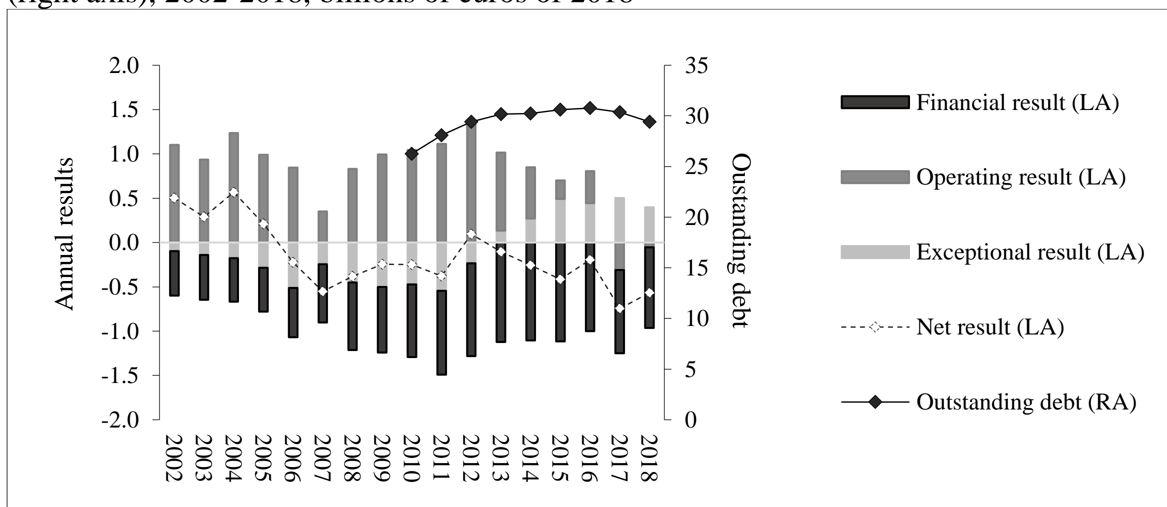
The increasing burden of interest payments has contributed to the deterioration of

[112] Figures refer to items of the main budget, which excludes long-term care services.

[113] Differently from the previous sections, in this case the item "financial results" include transactions with both banks and financial markets. However, except in some cases (as discussed next), public hospital debt comes primarily from bank loans.

hospitals' financial results and weakened their fiscal soundness. The sector's net result, which also takes into account regular health care activities (operating results) and other items (exceptional results) entered a new trajectory in the mid-2000s. Up to this point, the public hospital sector had a positive final balance, meaning they ended the year with a surplus. Starting in 2005, hospitals began to face recurring deficits in their overall accounts, with net results hitting minus €745 million in 2017. After 2012, this deterioration was aggravated by the steady decline of hospitals' accounts related to ordinary medical activities (operating results).

Figure 3.6 France, public hospital sector, annual results (left axis) and outstanding debt (right axis), 2002-2018, billions of euros of 2018



Source: author's elaboration based on DREES (2010-2014, 2015-2019). LA: Left axis. RA: Right Axis. Result: revenues minus expenses. Financial result: items related to debt and financial investments, including interest payments on borrowings. Operating result: items related to health care activities. Exceptional result: items related to management and capital operations, depreciation, and provisions. Net result: all results considered. Values for the global hospital budget. Real values of 2018 adjusted according to the Consumer Price Index (IPC/INSEE), except for 2018. 2018: nominal estimated values.

The role of the State

The French State was the chief actor behind the dramatic growth of interest-bearing capital as a means to finance public health infrastructure. The government implemented the new investment programs based on bank credit, simplified regulations to facilitate credit taking by hospitals, and subsidized debt repayments, to name a few. It also provided additional guarantees to investors. For example, amidst the hospital indebtedness crisis during the first half of the 2010s, the government actively countered the credit rationing of private banks by increasing the participation of public institutions. It also financed hospitals' early exit from toxic debts in 2014, putting in place a special fund to renegotiate the risky structured loans granted to hospitals. This fund was intended to raise money to finance the settlement of these debts before the original end date and to pay for indemnities associated with this early exit. The exit from "extremely high-risk loans" cost €678.8 million in total, from which 51% were financed by the public sector (12% by Ameli and 39% by public

hospitals) and 49% by the banks who provided these toxic loans (Cour des Comptes 2018).[114]

The French Supreme Audit Institution has analyzed the bank-based strategy and concluded that the State ended up facilitating access to credit more than effectively financing investments (Cour des Comptes, 2014). The institution highlights that the volume of credit concession and investments grew far more than was initially expected, but State subsidies did not grow accordingly. As a consequence, the guarantees facilitated the take-up of loans at first but the bulk of the debt burden remained with the hospitals, making them reduce their investment capacity subsequently. The idea that the government facilitated credit-taking but did not provide hospitals with sufficient financial security to repay their debts finds support in the data provided throughout this section. While investments grew in the 2000s but slowed down in the following decade, the channeling of funds from health care to the financial sector via interest payments remained consistently high. In this way, the new strategy failed in promoting a sustained increase in infrastructure investment, but fed financial accumulation.

Addendum: public hospitals venturing into financial markets

Much like Social Security agencies, some hospitals turned to financial markets in the 2000s. A number of public hospitals started issuing financial securities to finance investments and, later on, cover immediate cash needs. In both cases, these movements were pioneered by Assistance Publique - Hôpitaux de Paris (AP-HP), one of the main health care service providers for the French PHS.

AP-HP is a public university hospital consortium that operates in Paris and its surrounding areas. It is the largest medical research center in Europe and the largest employer of the Parisian region. In 2017, over one-tenth of hospital stays in France were in an AP-HP facility. The institution's revenues amounted to €7.9 billion in this year, more than 80% from Ameli transfers (AP-HP, 2018a). [115]

The institution entered the financial markets for the first time in 2000, issuing €41.3 million in long-term bonds to finance investments. In 2006, the institution began issuing medium-term notes, raising €173 million in that year. Two years later, AP-HP started issuing bonds in foreign currencies, which led it to also engage in derivatives (swaps) to hedge against currency fluctuations. Starting in 2016, the strategy of borrowing from markets was extended to short-term bonds, with a €308.7 million commercial paper program to cover short-term expenses. Given its size, AP-HP met the minimum legal requirements of scale required for borrowing in the financial markets on its own. Following its steps, relatively smaller institutions organized collective issuances to do the same. In 2009, 24 university hospital centers launched the first joint issuance program in the French public hospital sector, worth €298.3 million, followed by other programs thereafter (Chambre Régionale des

[114] Real values of 2018 adjusted for inflation according to the Consumer Price Index.
[115] Real values of 2018 adjusted for inflation according to the Consumer Price Index.

Comptes, 2016; Cour des Comptes, 2014).[116]

Financing conditions and intermediaries

We can gain further understanding of the conditions under which these programs work and the main financial players involved by taking a closer look at AP-HP's strategy. By the end of 2017, AP-HP faced an outstanding debt of €1.6 billion in medium- and long-term securities, at a length of approximately 10 years and an average cost (interest rates) of 2.2%. The debt in the form of financial instruments corresponded to 72% of the AP-HP's total debt, of €2.3 billion in total. The remaining 28% was in bank debt, equal to €640.6 million. Bank debt presented a similar length and a slightly higher cost than the financial debt, at 2.697% on average. Adding to that, there were still €54 million in debts from PPP contracts. This contrasts with the debt structure of the public hospital sector at large, where the share of debts from securities and bank loans accounted for 11% and 89% of total debt, respectively (AP-HP, 2018a). In 2017, AP-HP paid €52.5 million to investors and banks. From 2010 up to this year, financial charges amounted to €533 million in total (AP-HP, 2018b).[117]

The institution separates the buyers of securities into three categories: institutional investors (*institutionnel*), management funds (*fonds de gestion*), and banks. By 2017, these segments held 69%, 19%, and 12% of AP-HP outstanding debt, respectively. Most of this debt was held by foreign investors (55%). Seventy-one percent of the financial debt was denominated in euros, 18% in Norwegian krones, 6% in Japanese yens, and 5% in Swiss francs (AP-HP, 2018a). As in the other cases, the figures refer to primary placements, without taking into account eventual exchanges in secondary markets.

Also similar to the model used by CADES and ACOSS, the intermediaries of issuance programs include several private banks, domestic and foreign, such as ABN-AMRO, Natixis, HSBC, BNP Paribas, Merrill Lynch, Barclays, BRED, and Goldman Sachs (AP-HP, 2018b).

Taking Stock

This chapter examined mechanisms through which the French PHS has been integrated into the process of financialization. Our findings show that, since the 1990s, the system has adopted rationalities typical of the financial sector and rewired its financing circuits to make room for financial capital. This process occurred mainly through the adoption of financial instruments, which emerged as an alternative that would help address challenges related to traditional forms of funding. The Social Security system, responsible for the financing of the PHS, started issuing financial securities to refinance debts and finance short-term expenses. In the case of public hospitals, the backbone of service provision, the hallmark of this period was the massive recourse to bank loans to finance

[116] Real values of 2018 adjusted for inflation according to the Consumer Price Index.
[117] Real values of 2018 adjusted for inflation according to the Consumer Price Index.

investments. These strategies have come to replace previous arrangements based on public funding, either directly or via public financial institutions. Such a transition was actively promoted by the State, which altered regulations, provided implicit and explicit guarantees to the financial sector, and mobilized the necessary funds to pay for its costs.

The use of financial securities and loans opened channels through which domestic and foreign capital entered the French PHS (and the Social Security system more broadly), providing funds for various purposes and profiting from these businesses. In particular, these channels created pathways for part of these systems' revenues to flow to the financial sector to remunerate this anticipation of resources. In this way, we can say that the adoption of financialized policies in the French PHS was marked by both the use of financial instruments and the effects of such a shift in making them participate in financial accumulation strategies.

CHAPTER 4. THE BRAZILIAN SYSTEM: A TRAJECTORY (MIS)LED BY FINANCIALIZATION

This chapter shifts our focus from the center to the periphery of capitalism, investigating how the Brazilian PHS, *Sistema Único de Saúde,* has been reshaped by the financialization of the world economy. Unlike the experience of advanced countries, the Brazilian system was born when this process was already underway, and was integrated into it from a subordinate condition. This led to distinctive links between financial capital and the PHS. The Brazilian experience is particularly illustrative of how the rising influence of financial players, as well as the dissemination of their instruments and interests within the public sector, can change not only the ways in which a PHS manage its revenues but the very volume of resources it receives.

This chapter is organized into three sections. First, we provide critical background information by featuring the Social Security and public health systems in Brazil and describing the evolution of their financial accounts over the past decades. Next, we examine how the introduction of financialized policies in both the Brazilian economy at large and the PHS in particular has altered how the latter works. Using the same approach as in the previous chapter, we analyze transformations in long-term, short-term, and hospital financing. We discuss changes in long-term financing by unpacking how the adoption of a monetary policy framework geared toward financial accumulation has constrained the volume of funds available to the PHS since its early years. Next, we delve into issues of short-term financing, describing how public health agencies themselves have incorporated financial accumulation strategies to manage the system's revenues. We conclude by looking at hospital financing, studying the creation of government-sponsored credit lines for the hospitals providing services for the public system.

4.1. Social Security and public health care in Brazil

The Brazilian PHS, SUS, is part of a broader system of Social Security named *Sistema de Seguridade Social*. Its principles of organization, financing, and provision are heavily influenced by this larger institutional framework.[118]

4.1.1. The Brazilian Social Security system

The Brazilian Social Security system was created in 1988. Before the creation of Social Security, the public system of social protection in place was the Social Insurance system (*Instituto Nacional de Previdência Social*, INPS), created by the military regime in

[118] The characterization presented in this section draws from the compilation of information from Barbosa (1996), Gentil (2019) Lavinas (2021), and Souza et al. (2019).

the 1960s.[119] The Social Insurance system was a mandatory public pension scheme for private-sector workers, controlled by the State and restricted to work-related rights. It provided retirement benefits, pensions for dependents, disability allowances, unemployment insurance, and assistance for some other risks related to labor activity. Despite being in the hands of the federal government, it had typical "Bismarckian" features: the right to access was restricted to workers with formal labor contracts, benefits were funded by contributions on wages paid by employers and employees, and the value of benefits depended on the worker's contribution record. The scheme followed principles of solidarity to the extent that it was based on a simple distribution system ("pay-as-you-go", where the contributions of active individuals finance the benefits of inactive ones). In addition to employers and employees, the State was also formally required to participate in the system's financing. In practice, however, it often refrained from fulfilling its obligation.

The national insurance system created in the 1960s provided some form of health assistance for pensioners, formal workers, and, in some cases, their dependents. Still, the beneficiaries were entitled to a restricted scope of benefits, centered on access to medical care and hospital treatments within the system's service network. Individuals had access to a different range of services depending on their occupational category. The majority of the population, in turn, did not have access to the social insurance system and the health care network associated with it. This is not a surprise considering that the latter was mostly restricted to formally contracted workers. Unlike what was usually observed in wealthy countries, the share of workers with formal labor contracts in Brazil was small by the second half of the 20th century; as of 1986, less than 40% of Brazilian workers had formal occupations and access to social security benefits (ANFIP, 2019).

The first attempts to expand access to public pensions and health-related rights came in the 1970s. They consisted mainly of initiatives from the federal government to incorporate previously excluded groups into the social insurance scheme. These initiatives sought to extend the right to contribute to the system to previously excluded categories, such as domestic servants, rural workers, and the self-employed. Another relevant measure was in the direction of universalizing access to emergency care. Despite these efforts, the system of social protection in Brazil remained highly fragmented and exclusionary; a significant part of the population was still denied the right to participate, lacked the means to make regular contributions, or faced other administrative barriers that prevented them from joining the system. Estimates suggest that, by 1998, nearly 60% of private sector workers were not effectively covered by the public pension scheme (Previdência Social, 2000). This means that even a larger share was excluded from the previous (and more restrictive) scheme described here.

Apart from the health care assistance policies associated with the Social Insurance

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[119] The use of the term "Social Security" in Brazil follows that of Continental Europe, encompassing the entire social protection system including pension, health, and social assistance policies. This differs from how the term is used in Anglo-Saxon countries, where "Social Security" is most often used in reference to the pension system. To avoid conceptual misunderstandings, we refer to the national institute created in Brazil in the 1960s as a "social insurance" scheme (because it was focused on the pension system), in order to contrast it with the more comprehensive system created in 1988 which we refer to as "social security".

system, there were also a number of public health policies carried out directly by the State, more precisely the Ministry of Health. These were mostly focused on actions related to collective health, such as vaccination campaigns and actions for preventing and fighting contagious diseases. Another area with some degree of public intervention was hospital care, with government-sponsored referral hospitals specialized in specific conditions and groups of individuals. This array of policies formed a fragmented public network, with major gaps in both the services provided and the population covered by the public sector.

Alongside restricted public insurance and some State programs and hospitals, there was a diversified and relatively developed private health sector. Individuals with the capacity to pay could have access to private health practitioners and facilities via out-of-pocket payments. They could also benefit from private insurance schemes, either privately contracted or sponsored by their employers. The population at large, and especially the most disadvantaged groups, often relied on private charitable and philanthropic health care.

The key event leading to the creation of Social Security in Brazil in the late 20th century was the demise of the military government, which stayed in power from 1964 until 1985. This was a time of intense political mobilization to restore democracy and promote reforms to address the flaws of this regime. The setting up of a Constituent Assembly to elaborate a new legal order for the country created a particularly favorable context for the institution of a more inclusive social protection system. The approach to social rights and social protection was radically transformed with the approval of the 1988 Constitution, also known as the "Citizen Constitution" (Brazil, 1988). In one of its opening articles, the State recognized a series of fundamental rights and acknowledged its responsibility to ensure them to all citizens. It also introduced the concept of Social Security, comprising health, pensions, and social assistance policies, and created a special system to enforce rights in these three strategic areas – the Social Security system.

The 1988 Constitution established a set of fundamental principles for the newly-created Social Security system, which would explicit its core values and serve as a guide for present and future policy decisions. Among the most important, we can mention: (i) universality of coverage, (ii) uniformity and equivalence of benefits among different groups, (iii) equitable participation in funding (matched to income levels), and (iv) democratic administration through the joint management of workers, employers, retirees, and the government (Brazil, 1988).

In organizing a Social Security system according to such principles, Brazil sought to emulate the comprehensive and redistributive nature of the European systems created in the post-war period. It instituted features typical of the Beveridgean or universalist model of social protection (chapter 2), consisting of a State-controlled system that applied common criteria to individuals with different contribution records and counted on a diversified financing pool including revenues from general taxation and social contributions. These Beveridgean traits were particularly salient in the case of health and social assistance. In the case of pensions, however, many aspects of the former system of Social Insurance remained in place. For example, instead of conforming to the principle of universality, promoting a single retirement system for all the population, the State preserved privileged schemes within

the public administration and subsidized complementary private retirement and health insurance for part of the civil service. In this way, what emerged in practice was a hybrid model conjugating features from the previous logic of Social Insurance and the new logic of Social Security.

In terms of organization, the Brazilian Social Security system is divided into three subsystems:

- The public health system, named Unified Health System or *Sistema Único de Saúde* (SUS). It protects the population against health-related risks, providing health care services to all the population free of charge to the patient.
- The public pension system, the General Regime of Social Insurance or *Regime Geral da Previdência Social* (RGPS). It is a mandatory scheme for formal private sector workers and open to the rest of the population upon contribution. It protects against work-related risks, providing retirement benefits, allowances for dependents, unemployment insurance, sick leave, maternity and parental leave, among others.
- The public system of welfare assistance, the Unified Social Assistance System or *Sistema Único de Assistência Social* (SUAS). It covers vulnerable groups of the population against risks of subsistence and different forms of exclusion. The essence of its policies consists of cash transfers to low-income individuals who fall into specific categories. Unlike other schemes, social assistance benefits may not constitute vested rights.

The Social Security system has its own budget, the Social Security Budget (*Orçamento da Seguridade Social*, OSS), separated from the Fiscal Budget of the federal government (*Orçamento Fiscal*, OF). The OSS is endowed with earmarked revenues that in principle could only be allocated to the three areas covered by the system. The Constitution defined that the sources of revenues for Social Security should reach a wide range of income bases, including tax revenues from the fiscal budgets of national and subnational government, social contributions levied on the revenues of workers and companies, other contributions paid by workers and other individuals insured by Social Security, the revenues of lotteries, and import revenues. In practice, the system's financing depends almost entirely on social contributions, while government provisions from tax revenues account for a marginal share of revenues (Brazil, 1988).[120]

The State, more precisely the federal government, controls the Social Security Budget.[121] About half of the revenues to finance the PHS comes from Social Security, and this corresponds to the share of public health financing provided by the federal sphere.

[120] During the period under analysis (1990-2018), the system went through several changes with regard to organization, financing, and provision. This characterization focuses on the prevailing features of the Social Security system throughout this period.

[121] Brazil is a Presidential Federated Republic with 26 states, the Federal District, and approximately 5,570 municipalities. There are three levels of government: federal, state, and municipal. The federal government administers the national territory, and it is often referred to as the "Union". States and municipal governments rule within their jurisdictions and will be collectively referred to as "subnational governments".

Unlike the other sectors of Social Security, the PHS also depends on revenues from subnational governments (which do not control the Social Security system), as will be shown in the next section.

In broad terms, the financing circuits of Social Security begin with taxpayers, who address funds to the government. The federal government forwards revenues from federal taxes and social contributions to the Ministries in charge of health, pension, and social assistance policies. Each Ministry allocates the incoming revenues in its respective budgetary entity, known as "Funds" – the National Health Fund, the General Social Insurance Regime Fund, and the National Social Assistance Fund, respectively. The Ministries and subordinate bodies execute the payments. In the case of health care, Social Security revenues are used to make direct payments to service providers and other organizations (to cover the costs of health actions and service provision) and monetary transfers to state and municipal governments (contributing to the implementation of public health policies at the subnational level). These circuits are illustrated in Figure 4.1 presented in the next section, which also accounts for the financing circuits of the PHS that are not directly connected to the Social Security system.

4.1.2. The Brazilian public health system: Sistema Único de Saúde

Overview[122]

Brazil is one of the few middle-income countries with a public and universal health system covering all levels of care. The Brazilian PHS, SUS, is the largest universal health system in the world in terms of population coverage, reaching more than two hundred million people. The system represents a milestone in the history of universal health care as it was created under the yoke of neoliberalism and financialization, when several other countries were waging campaigns against State intervention in health care. Yet, the constraints imposed by this context pose enormous difficulties for making universal access to health care a reality. The particular trajectory of the Brazilian PHS in the neoliberal period led to a case full of contradictions; Brazil is also the only country with a universal health system where private health spending exceeds public health spending. In the next paragraphs, we will deconstruct the ways in which the system organizes, finances, and provides services to the population. This will be important to apprehend, at a later moment, some of the mechanisms by which neoliberalism and financialization have influenced SUS' trajectory and contributed to this current situation.

As noted in the previous section, until the creation of Social Security in 1988, the range and quality of public health care services available for each individual were determined according to his or her income and occupational status. The public health network provided under the Social Insurance scheme was discriminatory and based on a privatized model. A significant part of the services was delivered by private providers, sponsored by the federal

[122] The overview presented in this section is based on the works mentioned in the previous section (footnote 118) in addition to Bahia and Scheffer (2018), Barros and Piola (2016), Funcia (2019), Giovanella et al. (2012), Mendes (2012), Nugem et al. (2019), and Senado Federal (2018). When using a data or idea extracted from one specific work, we indicate the source of information from which it was retrieved.

government with public resources (especially from pension contributions). This arrangement was heavily criticized by social groups with more progressive agendas, in particular the members of the so-called "sanitary reform" movement.[123]

The promulgation of the 1988 Constitution and the creation of the Social Security system brought about a radical change in the State's approach to health care. The new text provided for the universality of health care, stating that "*health is a right of all and a duty of the State*" (Brazil, 1988, art. 196). SUS was formally created two years later, with the enactment of the so-called "Organic Health Laws" (Brazil, 1990a, 1990b).

Beyond the principles of Social Security, SUS also has its own set of directives. SUS principles of operation include (i) universality (every citizen is entitled to use the system irrespective of personal income, occupational status, or participation in private schemes, (ii) completeness (it provides services in all levels of care, from prevention to healing and rehabilitation), (iii) equality (no discrimination or privilege in access to services), and (iv) community participation (different social groups, including the civil society, participate in decision-making processes). Although this is not formally listed as a principle, the legislation also provides that SUS services are entirely free at the point of delivery (Brazil, 1990a). Such principles bring the model followed by Brazil closer to those of some wealthy nations and set it apart from the systems of most other Latin American countries.

SUS has a decentralized management structure. The three levels of government (federal, state, and local governments) are jointly responsible for financing and running the system. The federal government, via the Ministry of Health, is in charge of planning, coordinating, regulating, and overseeing the SUS programs, actions, and services. State governments, more precisely the State Health Secretariats under their control, are tasked with organizing and articulating SUS actions and services across the municipalities within their territory. Municipal governments, through their Municipal Health Secretariats, are mainly responsible for executing policies and delivering services. Higher levels of government may participate in service provision, especially when these involve more complex levels of care.

The system's financing also depends on the three levels of government. The federal government, each state, and each municipality allocate a predefined amount of revenues to health spending each year. Each level of government allocates the revenues earmarked for health spending into its respective Fund – the National Health Fund in the case of the federal government, and the State or Municipal Health Secretariat's Fund in the case of each state and municipality. This amount is defined throughout the annual budgetary process. The Executive branch of each government decides this amount in advance, during the elaboration of the annual budgetary law for the following year. This value is set taking into account

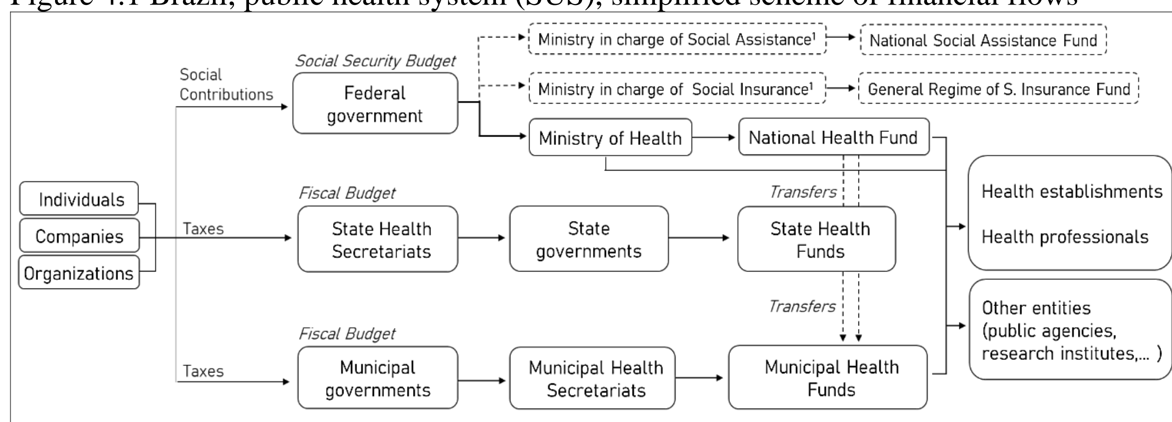
[123] This was an intellectual and political movement created in the 1970s bringing together university professors, medical students, health professionals, trade unionists, left-wing party activists, and other activist groups. The "sanitarists" were highly critical of the system in place and campaigned for a transformation in the country's health system, with the creation of a truly unified and universal scheme. The sanitary reform movement represented a first important step for the creation of SUS: they found space to advance their ideas during the constitutional debates of the late 1980s, countering movements in defense of a privatized system and influencing the creation of SUS.

government plans and the volume of public revenues expected for the following year. The predefined value for public health spending is approved by the Legislative and can be adjusted over the course of the given year. Once these are expected disbursements, it is often the case that the amount of resources effectively allocated to the health system is smaller than the amount of public health spending originally announced by the government.

Having a clear view of how revenues circulate within the system is crucial for understanding the mechanisms through which these circuits can be rewired and connected to the financial sector. Drawing from the review provided so far, we can trace the key stages of SUS financing circuits (Figure 4.1). They start with the population, companies, and other organizations, who pay taxes and contributions to the federal, state, and municipal governments. The federal government allocates its share of funds to the Ministry of Health, which allocates them to the National Health Fund. In the case of the federal and state governments, a significant part of health spending does not come in the form of direct payments to health actions and services, but as mandatory and voluntary transfers to the lower levels of administration. The volume of transfers received by each government depends on several factors such as the size of the population and the enrollment in national or state health programs.

States and municipalities, for their part, allocate revenues to their respective Health Secretariats, which places them in the Health Funds. In the case of states, part of their spending consists of transfers to the municipalities within their jurisdiction. The Health Ministry and Secretariats forward funds to public and private entities that work for SUS. These include hospitals, public health units, research institutes, and other parts of the public administration, to cite a few. SUS funds cover current and capital expenditures, including wages, inputs (materials, equipment, drugs), and infrastructure investment. SUS also provides financial supports to other entities responsible for actions such as research and teaching activities, sanitary surveillance, and community health programs.

Figure 4.1 Brazil, public health system (SUS), simplified scheme of financial flows



Source: author's elaboration. [1]There have been several changes in the name of these Ministries over time.

Over the 2010s, the federal and subnational governments were responsible for around half of SUS revenues each. The sources of revenues vary. The share from the federal

government refers to the sum coming from the Social Security Budget, controlled by the latter, made almost entirely from social contributions. State and municipal governments provide funds from their Fiscal Budgets, based on tax revenues and transfers from the upper levels of government. There is also a marginal share of funds from complementary sources, such as part of the proceeds from a mandatory fee charged by the federal government on all vehicle owners.

SUS follows what is typically identified as the "national health service" model (chapter 2). This means that the government is directly responsible for service provision, through public or contracted private providers. The system offers the largest share of health facilities and beds in the country. This share comes from both public and private establishments, the latter comprised mainly of nonprofit institutions working partially or entirely for SUS. According to the Brazilian Federation of Hospitals (FBH, 2019), the public and the non-profit sector together accounted for 68% of hospitals in the country in 2017 (35% in the public and 28% in the non-profit sector).

The interaction between SUS and the private health sector follows a "duplicate" logic (OECD, 2004), meaning that they offer the same services in a parallel fashion. Private health actors are free to operate in the country. Private insurance can be purchased directly or are accessed as part of a working contract. Individuals with private health insurance continue enjoying full access to the public system. During the last decade, the share of the population with access to private health insurance has varied between a quarter and a fifth. They accounted for 47 million in 2018, out of a population of 208 million people (IBGE, 2020a; ANS, 2019a). The number of private insurance beneficiaries turns Brazil into the second largest market of private voluntary health insurance in the world, only behind the United States (Deloitte, 2014). These are almost equally distributed across for- and not-for-profit insurance companies (ANS, 2019a).

These figures suggest that the share of the population without private insurance, which corresponds to more than 150 million people, depends entirely on the public system or out-of-pocket payments. Considering the high levels of poverty and inequality in the country, it is safe to say that SUS represents the primary or only gateway to health services for the majority of the population.

In practice, the public and the private spheres are interdependent, with one often filling the other's gaps. On the one hand, SUS covers private sector deficiencies in areas in which the latter does not have the capacity or interest to operate. Data on the use of SUS services by privately insured individuals suggest that they resort to the system when needing to access activities of high costs and risks (ANS, 2019b, 2018). This suggests that individuals who are insured or pay for private services still use the public network when their insurance coverage or capacity of payment is insufficient to access services through the market. Moreover, the entire population relies on SUS in some areas that are almost exclusively covered by the latter. These include vaccination campaigns, mobile emergency care, and actions of health surveillance and disease control, to mention a few (Bahia and Scheffer, 2018; Paim et al., 2011; Sestelo, 2017a). On the other hand, the private sector has large participation both inside and outside SUS structures. Inside SUS, private entities offer infrastructure and services on behalf of the public system. The private institutions that work for SUS remain

private, autonomous, and are paid directly by the latter.

The quest to consolidate universal health care: successes and drawbacks in the neoliberal period

In Brazil, the universal right to health care was not achieved gradually but through a paradigm shift in 1988. However, the creation of SUS was only the beginning of the path toward universalization. Making access to health care universal in practice required expanding the system's network to reach the entire population and provide services at all levels of care. Such goals could not be met without structural policy shifts in provision and financing. In both cases, the most significant shifts came in the 2000s.

From the side of provision, the government implemented several measures to consolidate and expand SUS programs, actions, services, and infrastructure. The expansion of primary care was the main vector of change. Aside from basic services, SUS also invested in complex levels of care. By the mid-2010s, the system enjoyed international recognition in several areas such as vaccination programs, generic drugs, HIV treatments, and organ transplants. The creation and expansion of the PHS in Brazil brought significant improvements to population health. To mention a few examples, there was a substantial decline in preventable deaths in all age groups, with a major drop in the infant mortality rate and deaths from communicable diseases. Life expectancy has increased by almost ten years between the early 1990s and the late 2010s (Bhalotra et al., 2019; IBGE, 2020a; Souza et al., 2019; UNICEF, 2019).

Notwithstanding these advances, there were clear privatization tendencies inside SUS. This can be seen in the progressive delegation of public infrastructure construction and management to private organizations, the outsourcing of medical and ancillary services to private providers, and the authorization of private practice in public establishments, to cite a few developments. The increased participation of the private sector in public structures has been criticized in light of evidence that this contributes to deteriorate working conditions, increase selectivity in the services offered to the public, and create high compensations for managers based on public revenues, among others (Andreazzi and Bravo, 2014; Bahia and Scheffer, 2018; Lima, 2018; Mendes and Funcia, 2016; Morais et al., 2018).

From the side of financing, there were constitutional reforms seeking to overcome the main obstacle to the consolidation of universal health care in Brazil, the lack of resources to finance service provision. In the years immediately after the creation of SUS, the unstable and insufficient level of revenues allocated to the system constrained the expansion of health actions and services. Although the 1988 Constitution determined that 30% of the Social Security budget should be allocated in the health branch, the federal government never complied with this rule. Instead of enforcing it, the government decided to create new financing rules to strengthen the system's financial soundness.

The first type of measures to address SUS funding gaps came still in the mid-1990s, with the introduction of additional sources of revenues for the system. The most significant one was a contribution on financial transactions, the Provisional Contribution on Financial

Transactions (CPMF). This contribution was instituted in 1996 and extinguished in 2007, followed by failed attempts to recreate it. Still on the revenue side, a second important moment came with the binding of 25% of oil royalty proceeds to health spending in 2013.[124] However, these incremental measures were insufficient to bring a significant increase in the volume of resources allocated to SUS (Piola et al., 2000; Souza et al., 2019).

The second type of reform, starting in the 2000s, came from the expenditure side. It was centered on the approval of "spending floors", a minimum mandatory amount that each government should spend on public health each year. The rules were introduced in 2000 and reinforced in 2012 (Brazil, 2012, 2000). In the case of the federal government, the mandatory spending floor was tied to economic growth; the government should spend at least as much on health as it did the year before, plus a percentage equal to the GDP variation. For subnational governments, expenditures were pegged to fiscal revenues; states and municipalities should spend at least 15% and 12% of their fiscal revenues, respectively. In 2015, the parameter for the federal government was modified and was tied to the volume of current revenues (Brazil, 2015a). These rules had a positive and significant effect on public health spending. However, they were partially repealed in 2016. In this year, the government completely reversed the logic of spending floors, defining a maximum instead of a minimum level of health expenditures by the federal government (Brazil, 2016a).[125]

A final set of policies carried out during the thirty years of SUS's existence with a direct impact on its financing consist of tax incentives. Although these are common to many countries, the particularities of tax incentives in Brazil make these measures particularly harmful to public health financing. Tax expenditures, also known as tax breaks or tax reliefs, reduce the tax burden on individuals and companies to encourage or compensate them for a certain activity. The range of activities to which the government grants tax waivers and the proportion of the public budget they absorb are far greater in Brazil than in other countries with universal health systems. For example, today, the national legislation allows individuals and companies to deduct virtually any spending on private health services and insurance plans from their taxable income. Individuals can deduct expenditures with insurance premiums, consultations, exams, and hospital treatments (even aesthetic surgeries), while companies enjoy large tax breaks on the payment of private insurance premiums to employees. Pharmaceutical companies and philanthropic hospitals also receive massive tax exemptions (Nugem et al., 2019; Ocké-Reis, 2018).

Moreover, the largest share of tax exemptions is granted through the waiver of social contributions, the chief source of revenues for the Social Security budget. According to estimates from the Federal Revenue Service, between 2010 and 2018, the value of tax exemptions granted by the federal government averaged 4.2% of the GDP per year; more than half of this amount – 52%, on average – came from waivers of Social Security contributions (Receita Federal, 2009-2017). Put otherwise, these benefits are provided by forgoing revenues that would otherwise go to SUS and other areas of social security. Only a

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[124] Oil royalties are payments made by companies to the State for the right to oil exploration, drilling, and production.

[125] This latter policy shift will be discussed in further detail in section 4.3.1 due to its links with government strategies that promote financial accumulation.

marginal share is compensated by the State to avoid direct losses in these areas (ANFIP, 2019, 2014; Gentil, 2019; Ocké-Reis, 2018; Salvador, 2015).[126] Considering the volume of tax exemptions, their impacts on the Social Security budget, and that they are mostly not compensated, several authors consider this policy a chief factor to explain SUS chronic underfunding – that is, its incapacity to receive the volume of revenues required for delivering the quantity and quality of services compatible with a universal public system (Funcia, 2019; Lavinas, 2017; Ocké-Reis, 2018).

The public health system today

The Brazilian PHS has never counted on a volume of funding comparable to that of wealthy countries (Table 4.1). The share of public spending in total health spending is close to that of the United States, known for having a highly privatized system. This share is almost half of that in France and England, core countries with universal systems. Public spending levels are also far below those of wealthy countries in terms of GDP. The gap is even wider in *per capita* values, with public spending accounting for approximately half of the world average and one-tenth of the other selected countries. The private health sector has experienced significant growth over the last two decades, much supported by the lack of sufficient spending in SUS and incentives from the federal government. This can be seen by the fact that total health spending, accounting for public and private sources, is relatively high in terms of the GDP, being above the world average and similar to that of European countries.

Table 4.1 Brazil and selected countries, total and public health spending, 2016

	Share of total health spending (%)	Health spending (% of GDP)		Per capita health spending (USD)	
	Public	Public	Total	Public	Total
Brazil	43	4	9.2	344	801
France	73	8.4	11.5	3,100	4,268
United Kingdom	80	7.9	9.9	3,268	4,066
United States	50	8.6	17	4,977	9,878
World average	52	3.5	6.6	686	1,028

Source: WHO (2020). Own elaboration. Per capita spending in current values. The share of public spending in total spending may vary depending on the selected indicator for reasons of methodology and rounding. Public spending: Domestic General Government Health Expenditure.

The restrictions on public spending translate into difficulties for consolidating the universal system. This challenge becomes particularly evident from a comparative perspective. As with the volume of resources, the public system has never been able to reach results like those countries with consolidated public systems. The WHO's 2000 ranking

[126] Own calculations based on real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Considers tax exemptions to all activities (in health and other sectors). The average exchange rate of December 2018 was of 4.3 Brazilian reais per euro. See ANFIP (2019), Cordilha (2015), and Ocké-Reis (2018) for studies using different methodologies but reaching similar conclusions on the share withdrawn from the Social Security budget.

mentioned in the previous chapter placed Brazil in 125th place out of 191 countries in terms of the overall quality of the national health system (WHO, 2000). In 2016, a new classification ranked the country in 96th place among 195 nations (Fullman et al., 2018). Life expectancy indicators, which are heavily influenced by the quality of access to health care, also remain below other countries with universal systems (WHO, 2020). Criticism is often directed at the quantity and quality of the services provided. Examples include the limited availability of inputs and professionals, the rationing of treatments, long waiting times, management issues, and precarious working conditions. The regional and social inequalities in access to care due to the disproportionate distribution of services throughout the territory are another object of ongoing debate.

From another angle, SUS supporters argue that the system can be considered highly efficient given the disparity between, on the one hand, the vast scope of services it offers and, on the other, the low levels of revenue it receives. In 2016, public per capita spending in Brazil was approximately US$344 per year (Table 4.1), or 0.9 cents per day; as reminded by Funcia (2019), this value is far inferior to both the revenues received by other universal systems and the value that private companies would consider economically feasible if they were to provide the same scale and scope of services offered by SUS.

4.2. SUS accounts in perspective

This section provides an overview of the structure and trajectory of SUS financing since the 1990s. We pay special attention to how different actors contribute to the system *de facto* (i.e., who provides funds, how, and how much), the volume of money that entered the system in this period, and where it was spent. This information will help to better describe the mechanisms by which financial capital gained participation and influence within the system.

Our analysis begins by showing the weight of SUS in the Social Security budget (Table 4.2). The table shows the evolution of the Social Security budget and the share of this budget occupied by the Ministry of Health, responsible for SUS at the federal level. Three trends stand out in this table. First, one can see that a minor share of the Social Security budget goes to the public health system. The expenditures from the Ministry of Health represented a relatively low and stable share of total Social Security expenditures during the period under analysis, at around 15% (XIX). Since the federal government controls this budget, the share of SUS financing coming from Social Security may serve as a proxy for the amount of financing provided by this government.[127] Second, the expenditures in health increased in absolute terms but remained relatively stable in terms of GDP (VII, XVI). Third, as commented earlier, Social Security revenues are almost entirely drawn from social contributions (II, XI), accounting for more than 95% of total revenues.

There are financial imbalances in the Social Security system (rows IX and XVIII), although these deficits are a highly debated topic, including for methodological reasons (see Box 4.1). Whether real or artificially created, it is commonly agreed that these deficits derive

[127] The share coming from the federal budget can vary according to the methodology to account for public health spending. The next tables offer an alternative view.

from the insurance branch (the pension system), which has by far the greatest weight in the Social Security budget. As health has relatively low participation, this branch has little influence on the system's apparent deficits. In this way, when referring to the financial challenges faced by the Brazilian health system, the notion of "underfunding" (the insufficient allocation of resources to fund all the actions necessary for adequate coverage) is far more widespread than that of "deficit" (a situation of not receiving sufficient resources to cover already incurred expenditures). The difference between decision-making processes for health and pension expenditures can contribute to explaining why the latter has a larger weight in this budget. In Brazil, health spending is discretionary, depending on the government's decision on how much to spend with in-kind provision. As we have seen, the only requirement for federal health spending was a minimum threshold (replaced by a maximum threshold after 2016). Pension spending, in contrast, is relatively automatic, as it consists of mandatory payments to individuals defined by existing contractual arrangements. In a context where the different areas of Social Security are competing for resources, pensions and related benefits tend to receive priority in resource allocation.

Table 4.2 Brazil, Social Security budget, 2005-2018, billions of reais of 2018 and % of the GDP

		2005	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*
	Billions of reais of 2018														
(I)	*Revenues*	*584*	*610*	*667*	*663*	*664*	*735*	*793*	*857*	*891*	*888*	*787*	*770*	*813*	*822*
(II)	Social contributions	559	585	640	636	638	709	765	826	870	861	760	739	785	793
(III)	Entities' own revenues	23	22	23	24	24	23	25	28	19	24	24	30	26	27
(IV)	Transfers - Fiscal Budget[1]	2	2	3	3	2	2	3	3	2	2	3	2	2	2
(V)	*Expenditures*	*438*	*492*	*535*	*546*	*607*	*643*	*676*	*729*	*772*	*798*	*780*	*829*	*872*	*875*
(VI)	Pension benefits	295	325	349	353	382	409	424	452	482	499	500	544	581	587
(VII)	Ministry of Health[2]	70	78	85	87	97	98	107	113	114	118	116	115	121	120
(VIII)	Others[3]	225	246	264	265	284	311	317	339	368	381	384	429	459	467
(IX)	*Balance (I-V)*	*146*	*118*	*132*	*116*	*57*	*92*	*117*	*127*	*119*	*90*	*6*	*-58*	*-59*	*-54*
	% of GDP														
(X)	*Revenues*	*13.3*	*12.9*	*13.0*	*12.1*	*11.7*	*11.8*	*12.0*	*12.5*	*12.4*	*12.1*	*11.5*	*11.5*	*11.9*	*12.0*
(XI)	Social contributions	12.8	12.4	12.5	11.6	11.3	11.4	11.6	12.0	12.1	11.8	11.1	11.0	11.5	11.6
(XII)	Entities' own revenues	0.5	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.4	0.4	0.4	0.4
(XIII)	Transfers - Fiscal Budget	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(XIV)	*Expenditures*	*10.0*	*10.4*	*10.5*	*9.9*	*10.7*	*10.3*	*10.3*	*10.6*	*10.7*	*10.9*	*11.4*	*12.3*	*12.8*	*12.8*
(XV)	Pension benefits	6.7	6.9	6.8	6.4	6.8	6.6	6.4	6.6	6.7	6.8	7.3	8.1	8.5	8.6
(XVI)	Ministry of Health	1.6	1.7	1.7	1.6	1.7	1.6	1.6	1.6	1.6	1.6	1.7	1.7	1.8	1.8
(XVII)	Others	1.7	1.9	2.0	1.9	2.3	2.2	2.2	2.4	2.5	2.5	2.4	2.5	2.5	2.5
(XVIII)	*Balance (X-XVI)*	*3.3*	*2.5*	*2.6*	*2.1*	*1.0*	*1.5*	*1.8*	*1.9*	*1.7*	*1.2*	*0.1*	*-0.9*	*-0.9*	*-0.8*
(XIX)	Min. of Health (% total expenditures)	16	16	16	16	16	15	16	15	15	15	15	14	14	14

Source: author's elaboration based on ANFIP (2019). Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Average exchange rate of Dec. 2018: 4.3 Reais/Euro. See Lavinas (2017) for an earlier version of this table. [1]Counterparts from the fiscal budget for pension-related payments. [2] Includes costs with active personnel and other operational and investment expenses. [3]Assistance benefits, direct expenditures from Ministries, and others.

Box 4.1 Methodologies to compute the
Social Security Budget in Brazil

There are at least two methods to compute revenues and expenditures in the Brazilian Social Security Budget. This difference in methodology is relevant because it leads to significantly different results in the Social Security budget. The main difference between these methods lies in the items of revenues and expenditures included in the calculation.

The first methodology is the one used by the National Association of Fiscal Auditors of Brazil's Federal Internal Revenue Service (ANFIP). It computes the sources of revenues and expenditures that the 1988 Constitution defined as pertaining to the Social Security budget.

The second methodology is the one adopted by the National Treasury Secretariat (STN). It computes a number of items that are not part of the Social Security Budget as provided for in the Constitution. Most importantly, the STN considers the revenues and expenditures of the pension system for federal servants and the military, which is not part of Social Security and is historically in deficit. It also discounts revenues from social contributions that are supposed to go to the Social Security system but are redirected to the Fiscal Budget of the federal government through an accounting maneuver known as the "Unbinding of Union Revenues".

Following ANFIP's methodology, the Social Security budget presents surpluses until 2014. The deficits from 2016 onwards are mostly explained by the decrease in revenues. Using the STN's methodology, in turn, the deficits appear at least since 1995, and are mostly attributed to growing expenditures. Over the past decades, the Brazilian government has traditionally opted for the latter approach to discuss Social Security issues.

For technical explanations on these different methodologies, see ANFIP (2019). For a critical discussion, see Gentil (2019).

The next set of data moves the analysis to the national level, presenting the total volume of public health spending and its distribution across the federal and subnational governments since the 1980s (Table 4.3). The official indicator to assess public health spending at the national level is the value of expenditures on "Public Health Actions and Services".[128] The series shows that public health spending grew continuously until 2014 and started declining from then on, triggered by the beginning of a sharp economic downturn. Most of the expansion came from subnational governments, especially municipalities, whose contribution more than doubled in this period (I to IV). In terms of GDP, however, public health spending remained almost stable, increasing by about one percentage point in two decades, once again almost exclusively due to the greater contribution from subnational spheres (V to VIII). The federal government continued to be responsible for the largest share of public health spending, but this participation diminished significantly to the detriment of

[128] The indicator "Public Health Actions and Services" (Ações e Serviços Públicos de Saúde, ASPS) includes expenditures with universal health care, epidemiological and sanitary surveillance, salaries, training, scientific and technological development, production, acquisition and distribution of inputs, basic sanitation, disease control, infrastructure spending, and administrative costs. Although it was created in 2012, this indicator is compatible with data for previous years regarding the relative participation of each sphere. This is not the methodology used in Social Security accounts, which explains the differences between the values of federal expenditures in Table 4.2 and Table 4.3.

subnational governments (IX to XI).

Table 4.3 Brazil, expenditures on public health actions and services (ASPS), 1980, 1990, 2005-2017, billions of reais of 2018, % of GDP, and % in total spending

		1980	1990	1995	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
	Billions of reais of 2018																
(I)	*Total*	*n.a.*	*n.a.*	*n.d.*	*156*	*171*	*182*	*198*	*212*	*223*	*241*	*252*	*263*	*274*	*267*	*266*	*277*
(II)	*Federal Govt.*	*n.a.*	*n.a.*	*n.d.*	*75*	*80*	*83*	*86*	*99*	*100*	*109*	*114*	*112*	*116*	*115*	*114*	*120*
(III)	*States Govts.*	*n.a.*	*n.a.*	*n.d.*	*40*	*45*	*49*	*55*	*55*	*60*	*63*	*64*	*70*	*73*	*69*	*68*	*71*
(IV)	*Mun. Govts.*	*n.a.*	*n.a.*	*n.d.*	*41*	*46*	*50*	*57*	*59*	*63*	*69*	*74*	*81*	*85*	*83*	*84*	*86*
	% of GDP																
(V)	*Total*	*n.a.*	*n.a.*	*3.0*	*3.6*	*3.6*	*3.6*	*3.6*	*3.8*	*3.6*	*3.7*	*3.7*	*3.7*	*3.8*	*3.9*	*4.0*	*4.1*
(VI)	*Federal Govt.*	*n.a.*	*n.a.*	*1.88*	*1.7*	*1.7*	*1.6*	*1.6*	*1.8*	*1.6*	*1.7*	*1.7*	*1.6*	*1.6*	*1.7*	*1.7*	*1.8*
(VII)	*States Govts.*	*n.a.*	*n.a.*	*0.54*	*0.9*	*1.0*	*1.0*	*1.0*	*1.0*	*1.0*	*1.0*	*0.9*	*1.0*	*1.0*	*1.0*	*1.0*	*1.0*
(VIII)	*Mun. Govts.*	*n.a.*	*n.a.*	*0.57*	*0.9*	*1.0*	*1.0*	*1.1*	*1.0*	*1.0*	*1.1*	*1.1*	*1.1*	*1.2*	*1.2*	*1.3*	*1.3*
	% in total spending																
(IX)	Federal Govt.	75	74	63	48	47	46	43	47	45	45	45	43	42	43	43	43
(X)	States Govts.	18	14	18	26	26	27	28	26	27	26	25	27	27	26	26	26
(XI)	Mun. Govts.	7	12	19	26	27	27	29	28	28	29	29	31	31	31	32	31

Source: author's elaboration. Data for health spending extracted from Mendes (2019) for 1980-1995 and Piola et al. (2018) for 2005-2017. GDP data: IBGE. Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Average exchange rate of Dec. 2018: 4.3 Reais/Euro. Mun: municipal. Govts: governments. N.a.: not available. Eventual differences between total and partial values are due to rounding.

We can break down health spending across different areas of activity to identify the areas where the federal and subnational governments spend the largest share of revenues. As a general rule, most of SUS expenditures are concentrated in activities of higher risks, costs, and technological complexity, represented by hospital and outpatient care. They absorb almost half of federal and municipal disbursements (II, IX). Still, there is a marked difference between federal and local spending patterns. While the federal government's participation is diversified (I to VI), subnational governments, most notably municipalities, allocate most of their funds in primary care and preventive actions (VIII).

Table 4.4 Health expenditures by subfunction, federal and local governments, 2000, 2005, 2010-2017, % total spending

<table>
<tr><th></th><th></th><th>2000</th><th>2005</th><th>2010</th><th>2011</th><th>2012</th><th>2013</th><th>2014</th><th>2015</th><th>2016</th><th>2017</th></tr>
<tr><td colspan="12">Federal Government (Ministry of Health)</td></tr>
<tr><td>(I)</td><td>Primary Care</td><td>32</td><td>21</td><td>17</td><td>18</td><td>18</td><td>18</td><td>20</td><td>19</td><td>19</td><td>18</td></tr>
<tr><td>(II)</td><td>Hospital and Outpatient Care</td><td>58</td><td>69</td><td>51</td><td>50</td><td>49</td><td>47</td><td>47</td><td>47</td><td>45</td><td>45</td></tr>
<tr><td>(III)</td><td>Prophylactic/Therapeutic Support</td><td rowspan="4">10</td><td rowspan="4">10</td><td>10</td><td>10</td><td>11</td><td>12</td><td>11</td><td>13</td><td>13</td><td>12</td></tr>
<tr><td>(IV)</td><td>Sanitary Surveillance</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>(V)</td><td>Epidemiological Surveillance</td><td>5</td><td>5</td><td>5</td><td>5</td><td>5</td><td>5</td><td>6</td><td>6</td></tr>
<tr><td>(VI)</td><td>Other Subfunctions</td><td>18</td><td>17</td><td>17</td><td>18</td><td>17</td><td>15</td><td>16</td><td>18</td></tr>
<tr><td>(VII)</td><td>Total</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td><td>100</td></tr>
</table>

(continue)

Local Governments (Municipalities)											
(VIII)	Primary Care	44.4	48.9	50.1	48.9	48.7	48.9	45.8	45.3	45.4	45.4
(IX)	Hospital and Outpatient Care	49.2	47.3	44.8	46.0	46.5	46.6	48.9	49.3	48.9	49.3
(X)	Prophylactic/Therapeutic Support	1.4	1.2	2.2	2.2	2.0	1.9	2.2	2.2	2.1	2.2
(XI)	Sanitary Surveillance	1.1	0.8	0.9	0.9	0.9	0.9	1.1	1.1	1.2	1.1
(XII)	Epidemiological Surveillance	1.7	1.7	1.9	1.9	1.9	1.7	2.0	2.0	2.1	2.0
(XIII)	Other Subfunctions	2.3	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.3	0.1
(XIV)	*Total*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*

Source: author's elaboration. For the federal government, data from Junior and Mendes (2015) for 2000-2005 and Ministério da Saúde (2019) for 2010-2018. For municipal governments, SIOPS (2019). Settled expenditures. There were significant changes in the way spending was accounted for between the two periods (2000-2005 and 2010-2017), therefore direct comparisons should be taken with caution.

Last, the challenges and contradictions of public health financing in Brazil become clear when comparing the share of national health care spending coming from the public and private sectors. Brazil stands out as the only country in the world with a universal health system where private spending outstrips public spending. The weight of each segment remained stable over the past years, averaging at 43% of total health spending financed by the public sector and 57% by the private one. The private share includes the participation of both insurance companies and individuals paying directly for services ("out-of-pocket" payments). Brazil bears yet another particularity compared with the pattern usually observed in countries with universal systems; the largest share of private spending derives from direct payments (out-of-pocket) rather than cost-sharing mechanisms (insurance), averaging 30% and 25% of total spending, respectively. The combination of private above public spending and direct over socialized cost-coverage suggests a highly inequitable structure of access to health care in the country.

Table 4.5 Brazil, health spending, public and private, 2000-2017, % in total health spending

	2000	*2005*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*
Public	42%	42%	45%	44%	43%	45%	44%	43%	43%	42%
Private	58%	58%	55%	55%	57%	55%	56%	57%	57%	58%
Health Insurance	*20%*	*21%*	*24%*	*25%*	*26%*	*26%*	*26%*	*27%*	*28%*	*29%*
Out-of-pocket	*37%*	*36%*	*29%*	*29%*	*30%*	*28%*	*28%*	*28%*	*27%*	*27%*
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: author's elaboration based on WHO (2020).

4.3. Mechanisms of financialization

Since the 1990s, SUS became increasingly entangled with the process of financialization. As discussed in chapter 1, this moment marked a new stage in the financialization of the domestic economy; the adoption of extremely high interest rates shaped a process driven by the accumulation of interest-bearing capital through public debt assets and the expansion of credit. This chapter bridges these developments in the domestic economy with the changes taking place inside the PHS. We will show how SUS was subjected to policies that both adapted the system to this context and transformed it into a vehicle for financial accumulation.

We examine how financialization influenced the trajectory of the system's financing

in the long run by describing the creation of permanent financial accumulation schemes fed by public revenues, including from SUS. The second part deals with short-term financing, more specifically how public bodies started engaging with short-term financial investments using the system's revenues. Moving on to hospital financing, we address the expansion of bank credit for hospitals providing services to the system, similarly backed up by public health revenues.

4.3.1. Permanent financial accumulation schemes fed by SUS revenues: policies at the federal level

The first and most significant way in which financialization has influenced SUS' trajectory came through the channel of monetary policy, more precisely through the adoption of an inflation targeting regime in 1999. This monetary policy framework led to two key developments in Brazil: one, permanently high real interest rates to help reach the inflation targets; two, specific fiscal and exchange rate policies to sustain this regime. The fiscal policy agenda was focused on creating government budget surpluses to service the public debt. As will be discussed, the government considered that these surpluses were critically important to price stability and therefore to the inflation targeting regime. SUS was incorporated into this process as the government appropriated from its revenues to form the surpluses – i.e., to save the funds that were addressed to the investors of the public debt.[129] Connecting these dots, we can say that the inflation-targeting regime led to a macroeconomic regime that constrained SUS funding, while the revenues that could potentially go to the system were used to pay financial rents.

It is important to note that the tendency of channeling public funds to the financial sector in detriment to investing in social provision is not exclusive to Brazil, having been considered a stylized fact of financialized capitalism (chapter 1). Yet, as we will show, the country is an outlier concerning the rigidity of the fiscal rules, the volume of funds they sacrifice, and the implications for the national PHS, which do not seem to find parallels with other countries that provide universal health care.

There is extensive literature on the relations between the dominance of financial capital in contemporary capitalism and the challenges faced by SUS (e.g., Lavinas, 2017; Mendes and Funcia, 2016; Mendes and Marques, 2009; Mendes, 2012; Paiva and Lima, 2014; Salvador, 2017; Sestelo et al., 2017). However, as a general rule, the focus of the analysis tends to lie on rules that withdraw resources from the Social Security budget to pay for financial expenditures. While recognizing the many contributions provided by this body of works, here we profit from the relatively new framework offered by the research on State financialization (chapter 1) to expand our view on the effects of financialization in SUS financing. This approach allows us to widen our scope of analysis in several ways. First, we can understand how this process affects not only the Social Security budget but also the fiscal budget of the federal and subnational governments, which is important since each of

[129] As explained in the introduction and chapter 1, inflation targeting has been considered a "financialized policy", meaning a policy that contributes to financialization, as it prioritizes the protection of financial investments and wealth over other goals that would be more beneficial to the population at large.

them participates in the financing of the PHS. Also, we can go beyond the perspective of fiscal policy and understand how monetary policies in the context of financialization may influence the former, and therefore the volume of revenues allocated to public health care. As we will show, monetary policy plays a crucial role in explaining the financialization of the PHS in the Brazilian case.

The 1999 monetary policy regime and its associated fiscal policy framework

While it is not possible to pinpoint a single cause for the high inflation rate recorded in Brazil in the 1990s, some events that can help to explain this trajectory include the international shocks of the 1970s (the 1973 oil crisis and the 1979 United States interest rate hike) and the domestic debt crisis in the 1980s (which came much as a consequence of these events). The policies used to counteract the debt crisis contributed to extremely high inflation rates in the 1980s and the early 1990s.[130] After a series of unsuccessful attempts to control inflation, the federal government managed to stabilize the economy in 1994 through the so-called "Real Plan" (Bastos, 2001; Bresser-Pereira, 2010; Brito, 2021).

The Real plan combined far-reaching reforms in the realms of monetary, fiscal, and exchange rate policy. It implemented a new currency (the Brazilian Real) and a fiscal adjustment program seeking to eliminate the government's budget deficit, deemed one of the root causes of inflation. The program promoted a major overhaul of the public administration, with tax reforms, spending cuts, and the privatization of public companies, among others. In the realm of exchange rate policy, the stabilization plan imposed an overvalued currency. This was, in practice, the key policy tool that allowed inflation to be curbed (Iahn and Missio, 2009; Oreiro, 2015; Serrano and Summa, 2011), putting downward pressure on domestic prices. The immediate years following the onset of the stabilization plan saw significant increases in interest rates to attract foreign capital and maintain the artificially overvalued currency. The period also saw the rise of public debt, imports, and external volatility. In the second half of the decade, the slowdown of domestic growth and financial crises in other countries reached an already fragile economy, leading to balance of payments crises, speculative attacks, and a massive loss of international reserves. The external crisis led Brazil to turn to the IMF in 1998 (Evangelista, 2017; Iahn and Missio, 2009; Ruckert and Borsatto, 1999).

In the context of structural reforms following the IMF agreement, the federal government instituted a macroeconomic policy framework in 1999 known as the "Macroeconomic Tripod".[131] The main goals of this framework were to control the rise of inflation and public debt. It was again based on the government's concerted action in monetary, fiscal, and exchange rate policy, expanding and consolidating some of the practices initiated by the Real plan. Most importantly, the government instituted an inflation targeting regime in this year, accompanied by budget rules that would serve to sustain it. The

[130] See footnote 24 for data on Brazilian inflation rates.
[131] Oreiro (2015) defines a macroeconomic policy framework as the set of goals, targets, and instruments of monetary, fiscal, and exchange rate policies, as well as the institutional framework within which they are executed.

decisions on public spending, including on health care, became subjected to the need to abide by such rules.

The Tripod's theoretical foundations rested on the idea that price stability was the ultimate objective of monetary policy. The latter became focused on controlling inflation, while fiscal and exchange rate policies were turned into instruments to help achieve this goal. The Tripod was based on the simultaneous pursuit of inflation targets in the monetary policy domain, budget surplus targets in the fiscal policy domain, and a floating exchange rate regime in the foreign exchange domain. The chief instrument to control inflation was the setting of the basic interest rate by the Central Bank, the "Selic", which was kept at significantly high levels. The rise in the basic interest rate controlled aggregate demand, but, most importantly, attracted foreign capital. This allowed maintaining a low exchange rate, curbing the rise of inflation. Although these rules have been partially relaxed in the decades that followed, its main tenets – inflation targets, budget targets, and a floating (now administered) exchange rate – continue in place up to today (Bresser-Pereira et al., 2020; Oreiro, 2015; Serrano and Summa, 2011).

Several studies show that the Brazilian interest rates are one of the highest in the world (Attilio, 2020; Bresser-Pereira et al., 2020; Lavinas, 2016; Reis, 2018; Weisbrot et al., 2017). Bresser et al. (*op. cit.*) study ten emerging countries with similar country risk levels between 2010 and 2014 and find that the country was home to the highest real short-term interest rate of the sample. In a similar vein, Weisbrot et al. (*op. cit.*) demonstrate that Brazil had the fourth-highest interest burden in the world out of 183 countries during a similar period. Also important, the level of basic interest rates dictates the direction of the remaining interest rates in the country. Lavinas (*op. cit.*) points out that, in early 2016, the nominal interest rate for personal loans and consumer credit in Brazil reached 92% and 142% per year, respectively. The author contrasts these rates with those of advanced countries when they experienced consumer credit *booms* during the 20th century, which stood below 20% in all cases studied.

Table 4.6 offers a panorama of the evolution of the basic interest rate in Brazil since the Real Plan. It also includes data for inflation to indicate the interest rate's evolution in real terms. The table reveals that the interest rate fluctuated but remained remarkably high in both nominal and real terms. In the second half of the 1990s (1996-1999), they stood at 27% per year on average, against a 6.3% rate of inflation. From 2000 to 2018, these rates were 13.5% and 6.4%, respectively.

Table 4.6 Brazil, interest and inflation rates, 1996-2018, % per year

	Basic interest rate (Selic)	Inflation (IPCA)	(cont.)	Basic interest rate (Selic)	Inflation (IPCA)
1996	27.5	9.6	*2009*	10.0	4.3
1997	25.2	5.2	*2010*	9.8	5.9
1998	29.3	1.7	*2011*	11.7	6.5
1999	26.1	8.9	*2012*	8.5	5.8
2000	17.6	6.0	*2013*	8.2	5.9
2001	17.5	7.7	*2014*	10.9	6.4
2002	19.1	12.5	*2015*	13.4	10.7
2003	23.3	9.3	*2016*	14.1	6.3
2004	16.2	7.6	*2017*	10.1	3.0
2005	19.1	5.7	*2018*	6.5	3.8
2006	15.3	3.1			
2007	12.0	4.5			
2008	12.4	5.9			

Source: author’s elaboration based on Banco Central (2020b) and IBGE. Selic: average annualized rate 252-days base. IPCA: Broad Consumer Price Index.

Against the same background, the federal government praised budget surpluses as the solution to prevent the rise of the public debt and its monetization in the long run, seen as a threat to price stabilization. The government expressed its commitment to controlling and servicing the public debt by defining budget surplus targets. These budget surpluses refer, more specifically, to “primary” surpluses. This seemingly unimportant specification has major implications for the PHS and its incorporation into processes of financial accumulation: in Brazilian public accounting, primary surpluses mean the difference between all public revenues and expenditures, except for financial ones (those associated with the public debt). Reaching primary surpluses implies that the government spends less than it earns with ordinary public activities within a year, which allows it to save revenues for financial expenditures – namely amortization and interest payments on the public debt.[132] The adoption of primary budget targets was already part of the adjustment plans of the mid-1990s, but it was formally instituted as a permanent practice in 1999 in the context of the inflation targeting regime.

The centrality of the budget targets in the “macroeconomic tripod”, as well as the role of spending cuts in sectors of social provision to achieve the latter, were openly acknowledged in the government’s “letter of intent” addressed to the IMF in 1998 (Brazil, 1998). This evidences how public debt and the demands of creditors and international financial institutions played an important role in putting this arrangement in place in Brazil.

The Brazilian government defines primary surpluses targets for the following years and promotes the necessary policy adjustments to reach them. The primary surplus targets

[132] The concept of primary revenues and expenditures refers to all public revenues and expenditures except for financial ones. Financial revenues and expenditures are those related with the public debt. The most important items of financial expenditures are the payment of amortizations and interests on the public debt. Primary expenditures comprise all government expenses except financial ones, namely current and capital expenditures with ordinary functions of the public sector (including with public health). The difference between primary revenues and expenditures is called the primary result. A positive primary result, or primary surplus, means the funds “in excess” that can be used to cover the financial result. For reasons of simplification, we will use the expressions “primary result”, “budget result”, and “fiscal result” as synonyms.

have been high. Between 1998 to 2010, they were set at 3% of the GDP, on average (Evangelista, 2017). From 2011 onwards, the targets were set in nominal values only (not as a percentage of the GDP), but the observed surpluses remained close to such ratios until the economic crisis of the mid-2010s. Under the "macroeconomic tripod", the Brazilian economy ran on high interest rates, solid fiscal surpluses, and an overvalued currency for most of the period from 1999 to the late 2010s.

Public sector accounts started to worsen by the end of the 2000s, suffering the effects of international crises. In the mid-2010s, Brazil plunged into a profound economic recession that prevented it from maintaining positive fiscal balances.[133] In 2014, for the first time since the establishment of the macroeconomic tripod, the government's primary result recorded a deficit rather than a surplus. The country recorded a double-digit inflation rate in the following year, at the same time that public debt was rising at a fast pace. Despite the economic downturn of the mid-2010s and the emergence of deficits in government accounts, the government continued imposing budget targets. The policy was maintained over the second half of the decade, only to move from minimum surplus targets to maximum deficit targets (Evangelista, 2017; Gentil and Hermann, 2017).

By not abandoning the fiscal targets, the government could maintain its ability to pay for financial expenditures even under adverse fiscal conditions. Such a hierarchy of priorities in public spending was not only preserved but reinforced as the economic crisis worsened. The prime example of new measures to preserve the existing strategies of financial accumulation was the adoption of spending rules by the federal government. These rules were designed to put the country "back on track", achieving positive primary surpluses. Put otherwise, they would help the government reduce primary spending, saving funds for financial expenditures on the public debt. This would ensure the sustainability of the macroeconomic tripod regime. The spending rules enacted in the second half of the 2000s were particularly problematic for areas of "discretionary" spending, such as health care. They had direct consequences for SUS financing, as explained in the following section.

Reinforcing the macroeconomic regime: health spending rules

In 2016, in light of its inability to meet the expected fiscal targets, the federal government created the so-called "New Fiscal Regime". This sought to reinforce its capacity to maintain the current macroeconomic policy framework. This regime did not replace but rather reinforced the existing framework focused on the dual objective of meeting inflation and budget targets. The government maintained the latter while adding rules that automatically limited public spending. This would help the government get closer to the annual budget targets and eventually restore the positive fiscal results achieved during the 2000s and early 2010s.

The new fiscal regime and its related spending rules were introduced through a constitutional amendment, the Constitutional Amendment 95, known as the "spending

[133] The Brazilian GDP growth rates were of -0.5% in 2014, -3.5% in 2015, -3.3% in 2016, 1.1% in 2017, and 1.1% in 2018.

ceiling rule" (Brazil, 2016a). The law's explanatory memorandum explains that its goal was to complement the existing instrument of fiscal stability for the short-term, the targets for primary fiscal results set for the following year, with an instrument for the medium and long-run, limits to primary spending valid for several years. This would allow meeting the highest possible primary result and contain the expansion of the public debt (Brazil, 2016b).

In practice, the spending rule approved in 2016 established a twenty-year freeze on federal annual spending. Total primary expenditure would have zero real growth: the federal government was allowed to spend, each year, the values spent on 2016, adjusted only for inflation. Public spending would not be able to increase in line with GDP, revenue, or population growth. In the case of health, the base year was moved to 2017 – meaning expenditures in health care would be frozen in real terms at the values spent in this year.[134] The new fiscal regime focused on the expenditure side, with no comparable measures to increase revenues on a permanent basis.

The rule applies exclusively to primary spending. This means that financial expenditures – public debt interests and amortization payments – are exempted from the ceiling. It becomes clear, thus, that the spending limits were a way to guarantee that the government would have enough funds to continue servicing the public debt. As corroborated by other authors (Funcia, 2019; Salvador, 2020), while the explicit objective of the budget ceiling was to stabilize the growth of primary spending to contain the rise in public debt, the implicit goal was to continue saving funds to service the debt even in times of economic turbulence.

The implementation of spending ceilings by way of a constitutional amendment overrode the previous constitutional rule that tied federal spending on SUS to GDP growth.[135] Under the new rule, if the government wants to increase the amount spent on health in relation to the previous year, it must compensate it by reducing expenditures in other sectors, so that the total amount of expenditures remains flat. In a context where different areas of the public administration compete for increasingly scarce funds, there is hardly any room left to expand investments in health, an area of discretionary spending. That there is no space even for an automatic increase in health spending to keep pace with population growth and rising health care costs means a level of restrictions on health care financing unseen in any other country with a universal health system. Dissociating expenditures from such variables leads to a decrease in *per capita* health spending, a trend that started during the crisis (2014) and became almost unavoidable after this rule (Bahia et al., 2021; Funcia, 2019).

Wrapping up the various elements presented in this section, we can argue that the inflation targeting policy regime and its associated fiscal rules represent a financialized policy framework that has a direct impact on SUS financing. This is because this framework reallocates federal spending from social services, including health care, to financial

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[134] The rule considers the values of public spending in monetary values, not in terms of the GDP. The government eventually approved an exceptional rule for education; in this case, federal spending should be equal to 18% of the net federal tax revenues of 2017, adjusted for inflation. The rule applies to the federal government only (although it directly impacts the value of transfers to the subnational spheres).
[135] In 2015, the year before the spending ceiling was approved, federal spending had been altered to revenue growth – see section 4.1.2.

expenditures, notably interests on the public debt. In practice, thus, it appropriates from SUS funds to feed financial accumulation. In the next section, we will move from the fiscal to the Social Security budget, showing the implementation of other rules for the same purposes – maintaining this macroeconomic framework in place, using funds from essential areas of public provision. Last, we will provide data to better illustrate how this monetary policy framework, by imposing high interest rates and fiscal targets, put a financial strain on the health care system.

Backing the macroeconomic regime: rules for Social Security revenues

The policy changes described so far focused on the fiscal budget of the federal government and the rules allowing it to save revenues to service the public debt. But the Social Security budget was also turned into a key source of revenues to sustain this strategy. The government started enacting rules to channel part of Social Security revenues to the fiscal budget in 1994, in the context of the Real stabilization plan. These were introduced as urgent and temporary measures, under the names of "Social Emergency Fund" (from 1994 to 1997) and "Fiscal Stabilization Fund" (in 1998 and 1999). In 2000, following the institution of the inflation targeting regime, the government passed the current version of this measure, the "Unbinding of Union Revenues" (Desvinculação de Receitas da União), commonly known as DRU.

The DRU works by altering the constitutional norm that binds social contributions to the financing of Social Security policies – i.e., public pensions, public health, and social assistance. During most of its existence, the DRU allowed the federal government to take up to 20% of social contribution revenues from the Social Security budget and allocate them into the fiscal budget. In 2016, this share rose to 30%.[136] The DRU is approved through constitutional amendments lasting from five to seven years each. Since it is enacted by constitutional amendment, it has the legal value of other provisions of the Constitution. Despite its provisional character, this device has been continually renewed over the years. The Executive proposes and the Legislative Chamber approves a new amendment renewing the DRU whenever the one in force is about to expire.

This measure does not provide additional revenues for the government. What it does is change the allocation of existing revenues within the public budget. However, in doing so, it becomes a central instrument allowing the current macroeconomic regime to remain in place. This is because the revenues moved through the DRU can be freely allocated into any area of public spending, not only those related to Social Security. As previously noted, the payment of public debt interests and amortizations are items of the fiscal budget. Therefore, the government would not be able to use revenues from social contributions to service the debt without the DRU, as these would be tied to the Social Security budget (Dias, 2008; Salvador, 2017).

The government justifies the untying of social contributions claiming that this allows

[136] Governments from different political stances engaged with the DRU. This increase was approved after the impeachment of the Workers' Party president in office (Dilma Rousseff) that year.

for greater flexibility in spending decisions, which would translate into more efficient public resource allocation. It also claims that the measure does not harm the financing of Social Security, as part of the revenues would return to the system via government transfers (Brazil, 1993). This latter argument has been contested by several studies, which demonstrate that the largest part of the revenues is withheld in the fiscal budget rather than going to Social Security. As they rightly emphasize, if the goal was not to move revenues across budgets, there would be no reason to create the rule in the first place (Dias, 2008; Gentil, 2019; Pinto, 2008).

While the stated goal of decoupling revenues from the Social Security budget is to optimize expenditure decisions, the measure serves the implicit and more important purpose of allowing the government to meet budget targets. In this way, revenues can be used to prioritize financial expenditures. In other words, the revenues of the Social Security system can serve other purposes, including paying public debt investors. Since the creation of the DRU, the revenues incorporated into the fiscal budget have been sufficiently large to eliminate or significantly diminish primary budget deficits and allow the government to reach the targets defined for the year. As a result, the volume of public funds available to pay for financial expenditures also increased (Dias, 2008; Gentil, 2019; Mendes, 2012; Salvador, 2017). It is telling that the role of the DRU as a tool to achieve fiscal targets and pay for financial expenditures was not openly acknowledged at first, but became explicit over time. Unlike the original legislation, by the late 2010s, the Senate's website listed among DRU's purposes "*the management of resources for interest payments on the public debt*" (Senado Notícias, 2020).

It is possible to know the overall amount of Social Security revenues withdrawn by the DRU, but there is little information on the specific purposes for which they were used afterwards. As the government does not disclose the destination of these revenues, it is virtually impossible to be precise about the share of social contributions destined to public debt interests and amortizations. Not even the public oversight authorities are fully aware of where the resources appropriated through the DRU go; in a report retrieved by Barbosa (2020), the Brazilian Federal Court of Accounts acknowledges that "*due to the method for accounting for DRU resources (...) it is not possible to determine the exact amount of the resources unbound from Social Security that would be funding the fiscal budget or returning to the [Social Security] sphere*" (TCU, 2007, p. 127). Academic studies that sought to retrace the path followed by these funds also underscore the lack of transparency and timely accounting information when it comes to these resources; even so, they find compelling evidence on their use to pay for financial expenditures (Mendes, 2012; Pitombo, 2019; Dias, 2008; Barbosa, *op. cit.*).

Several studies sought to estimate the effects of the DRU on SUS financing. Gentil (2019) finds that the sum withdrawn from the Social Security budget was greater than that allocated to health in all years from 1995 and 2015. Also according to the author's calculations, had these funds been allocated to SUS, they could have roughly doubled the investment in the system during this period, bringing about a radical transformation in the provision of public health services. Looking at the 2000s, Mendes (2012) shows that the proportion of resources absorbed by the DRU that returned to the Social Security budget was

almost negligible, and even more so the share of such revenues that was allocated to health. Last, Salvador (2010) demonstrates that the DRU was the chief source of funds for the primary surpluses achieved by the federal government during the 2000s. The author's estimations show that the revenues appropriated via DRU represented on average 62.5% of the federal government's primary surplus from 2000 to 2007. We will revisit this issue in the following section, where we present data to reinforce our argument that SUS funds have been appropriated by financial capital through fiscal rules saving resources for interest payments.

Data analysis and interpretation: health and financial expenditures in perspective

The evolution of monetary and fiscal indicators over the past two decades in Brazil demonstrates how this regime imposed a hierarchy in the use of public funds, prioritizing financial over health expenditures. This quantitative perspective can shed further insight on the links between financialization, the macroeconomic policy regime, and public health financing. First, we can show that the primary surplus target policy was successful in saving public funds to pay for public debt interests (Table 4.7). The monetary policy framework enforced permanently high interest rates. As the Brazilian interest rates are one of the highest in the world, so is the interest burden on the public debt. The federal government, responsible for the interest payments on the sovereign debt, committed an average of 4.6% of the GDP per year to interest payments between 2000 and 2018. In contrast to the deterioration of other fiscal indicators, interest payments increased during the recession (2015-2018), peaking at more than 7% of the GDP in 2015. This evolution cannot be attributed to the fall of the GDP, once the amount of interest payments rose in absolute values in 2015 compared to the pre-crisis period. In total, the federal government alone paid R$5 trillion in interest on the public debt over these eighteen years. The value of interest payments is even higher when accounting for all the public sector, at an average of 6.2% of GDP and R$339.4 billion per year.

To pay for public debt interest, the federal government achieved high budget surpluses each year from 2000 to 2013, averaging 2% of GDP. The federal budget began to show primary deficits from 2014 onwards, due to the strong economic recession of the period. From 2014 to 2018, the deficits averaged 1.9% of GDP. This did not prevent the continuation of public debt repayments. The enforcement of new budget rules contributed to maintaining a high and sustained volume of interest payments, including during the 2014-2016 economic crisis.

The growth of budget deficits in the last years of the series, coupled with higher interest burdens, was reflected in the evolution of public debt. This followed a downward trend until 2014, and increased from that point on.

Table 4.7 Brazil, fiscal policy indicators, federal government and total public sector[1], 2000-2018, % of GDP and billions of reais of 2018

	% of GDP					Billions of reais of 2018				
	Primary Balance (Federal)	Primary Balance (Total)	Interest payments (Federal)	Interest payments (Total)	Public debt (Total)	Primary Balance (Federal)	Primary Balance (Total)	Interest payments (Federal)	Interest payments (Total)	Public debt (Total)[1]
2000	1.7	3.2	3.6	7.3	n.a.	63.7	116.3	131.3	266.5	n.a.
2001	1.7	3.2	3.8	6.6	51.5	64.2	118.5	140.2	245.9	1,919
2002	2.2	3.2	3.3	7.6	59.9	83.5	121.3	126.6	289.2	2,278
2003	2.3	3.2	6.6	8.4	54.3	89.5	127.8	259.9	332.5	2,144
2004	2.7	3.7	4.4	6.6	50.2	113.1	154.9	183.8	275.6	2,107
2005	2.6	3.7	6	7.3	47.9	113.2	164.1	262.8	319.2	2,100
2006	2.1	3.2	4.9	6.7	46.5	101	148.8	229.9	317.3	2,195
2007	2.2	3.2	4	6.0	44.6	113	165.7	203.3	305.7	2,279
2008	2.3	3.3	3.5	5.3	37.6	126.9	183.1	191.9	292.6	2,066
2009	1.3	1.9	4.6	5.1	40.9	73.1	109.9	258.7	290.1	2,312
2010	2	2.6	3.7	5.0	38	127.3	163.3	228.4	313.8	2,370
2011	2.1	2.9	4.6	5.4	34.5	140.9	193.8	302.8	356.4	2,272
2012	1.8	2.2	3.7	4.4	32.2	123.9	149.8	250.8	305.2	2,212
2013	1.4	1.7	4.1	4.7	30.5	103.4	123.2	293.9	335.7	2,194
2014	-0.4	-0.6	4.7	5.4	32.6	-25.8	-41.2	346.7	394.3	2,384
2015	-1.9	-1.9	7.1	8.4	35.6	-132.9	-127.5	490.8	575.1	2,449
2016	-2.5	- 2.5	5.2	6.5	46.1	-169.8	-166.9	346.2	436.0	3,099
2017	-1.8	- 1.7	5.9	6.1	51.4	-122.6	-115.2	402.4	417.7	3,525
2018	-1.7	- 1.6	5.5	5.4	52.8	-115.6	-108.4	386.0	379.8	3,701
Avg.	1.1	1.7	4.7	6.2	43.7	45.8	78.0	265.1	339.4	2,422.6

Source: author's elaboration based on data from the Brazilian Central Bank (Banco Central, 2020b). Primary balance: non-financial revenues in excess of non-financial expenditures. Total: total public sector, including federal and subnational governments, the Central Bank, and other parts of the public administration. Data for 2000 includes Petrobras and Eletrobras. Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Average exchange rate as of Dec. 2018: 4.3 Reais/Euro. Net Debt. Nominal interest rates. Eventual differences between absolute values and relative to the GDP are due to rounding. N.a.: non-available. Avg.: average.

We can contrast how much the federal government spent on public debt interest and health care during most of the period following the implementation of the inflation targeting regime (Table 4.8). Central bank figures show a sizeable gap between interest and health spending; from 2000 to 2009, the federal government spent an average of 4.5% of GDP per year on public debt interest against 1.6% on health. This gap widened in the following decade, reaching 4.9% and 1.5% in 2010-2018, respectively. The progressive increase in debt spending contrasts with the virtually unchanged level of health spending. Similar trends can be observed when considering the absolute amounts allocated to each item; the federal government spent approximately three times more on interest than on health. Adding up the expenditures for the entire period, we find that the federal government spent R$5 trillion on interest against R$1.6 trillion on health.[137]

[137] We use data from the Central Bank, whose methodology considers net interest on the public debt (interest expenditures minus interest income). It is also possible to assess public debt interest charges with data from the National Treasury Secretariat, which considers gross net interest expenditures on the public debt by the federal government. The institutions also adopt different methodologies to account for health expenditures.

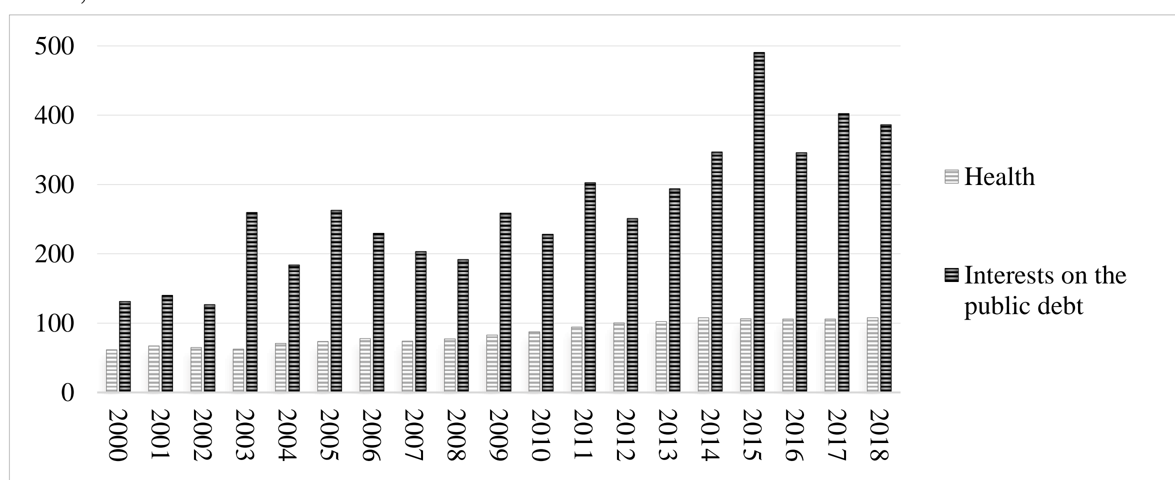
Table 4.8 Brazil, federal government expenditures on public debt interests and health, 2000-2018, % of GDP and billions of reais of 2018

	% of GDP		Billions of reais of 2018	
	Interests	Health	Interests	Health
2000	3.6%	1.7%	131.3	61.8
2001	3.8%	1.8%	140.2	66.9
2002	3.3%	1.7%	126.6	64.9
2003	6.6%	1.6%	259.9	62.5
2004	4.4%	1.7%	183.8	70.7
2005	6.0%	1.7%	262.8	73.7
2006	4.9%	1.6%	229.9	77.9
2007	4.0%	1.4%	203.3	74.2
2008	3.5%	1.4%	191.9	77.1
2009	4.6%	1.5%	258.7	82.6
2010	3.7%	1.4%	228.4	87.6
2011	4.6%	1.4%	302.8	94.3
2012	3.6%	1.5%	250.8	100.3
2013	4.1%	1.4%	293.9	102.3
2014	4.7%	1.5%	346.7	107.8
2015	7.1%	1.5%	490.8	106.5
2016	5.2%	1.6%	346.2	105.8
2017	5.9%	1.5%	402.4	105.7
2018	5.6%	1.6%	386.0	107.9
Average 2000-09	4.5%	1.6%	198.8	71.2
Average 2010-18	4.9%	1.5%	338.7	102.0
Total 2000-18	4.7%	1.6%	5,036.5	1,630.5

Sources: author's elaboration with data from Banco Central (2020b) for nominal interest payments and the federal government's annual "Summary Report on Budget Execution" (RREO) for health expenditures. Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Average exchange rate as of Dec. 2018: 4.3 Reais/Euro.

In Figure 4.2, we use data from this table to better illustrate the difference between the levels of federal spending on public debt interests and health.

Figure 4.2 Brazil, federal government expenditure on health and public debt interests, 2000-2018, billions of Reais of 2018

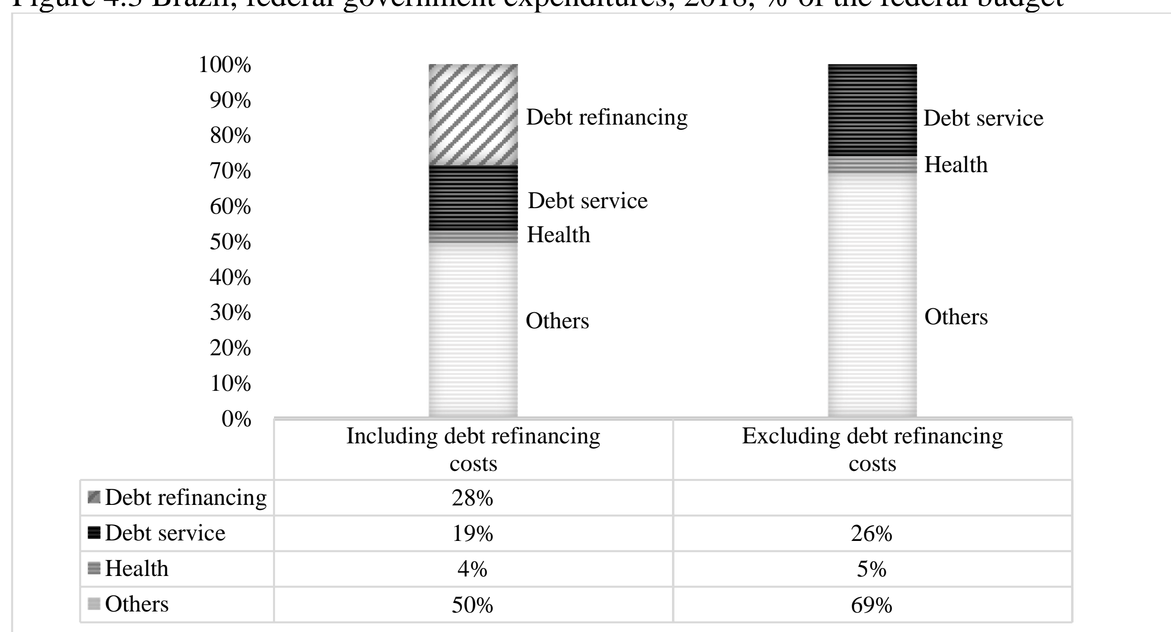


Source: author's elaboration based on Banco Central (2020b). Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Average exchange rate of Dec. 2018: 4.3 Reais/Euro.

Following the National Treasury's methodology, we find different values for interests and health, but a similar gap between them. Neither of the institutions separates the fiscal from the Social Security budget when providing data on health spending.

Alternatively, one can consider the share of the federal budget dedicated to financial and health expenditures (Figure 4.3). The method used to estimate this share is an object of great controversy in Brazil. We present the results obtained by following different approaches to show that the overall conclusion remains unchanged irrespective of the methodology used. The first approach considers that financial expenditures should include both "debt service" costs (the payment of interest and amortizations using current government revenues) and "debt refinancing" costs (the payment of amortizations using revenues coming from the issuance of government bonds). The second approach excludes refinancing items, as they supposedly do not compromise existing government funds.[138] Following the first approach, which accounts for public debt refinancing costs, data show that almost half of the government budget, 47%, was committed by public debt in 2018, while health absorbed a marginal share, 4%. Following the second approach, without refinancing costs, financial expenditures still represented 26% of government expenditures, against 5% for health. In either case, the volume of public funds channeled to the financial sector was nearly five times higher than that destined for health care.

Figure 4.3 Brazil, federal government expenditures, 2018, % of the federal budget



	Including debt refinancing costs	Excluding debt refinancing costs
Debt refinancing	28%	
Debt service	19%	26%
Health	4%	5%
Others	50%	69%

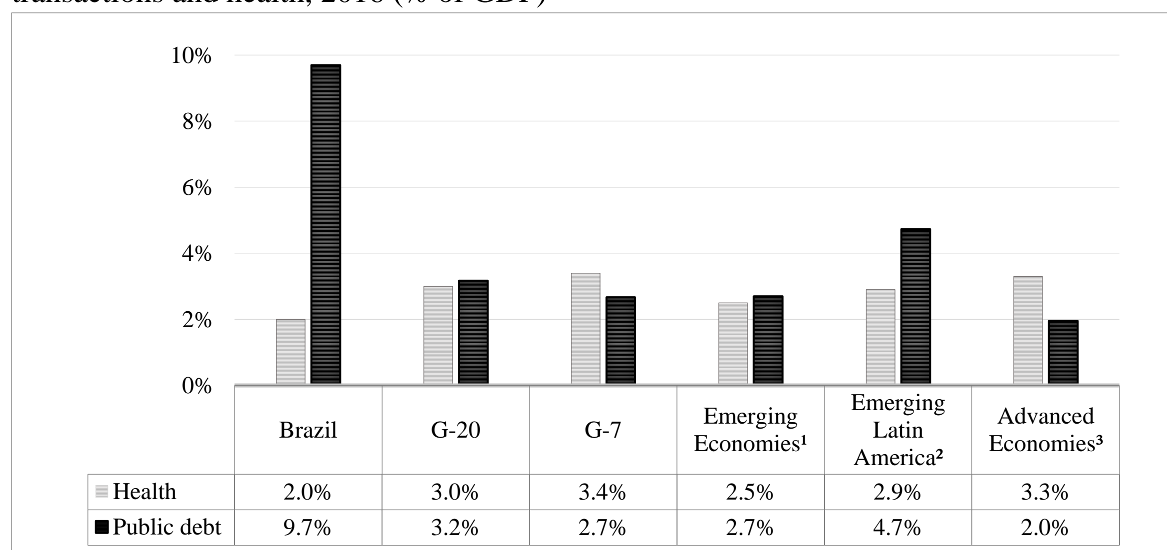
Source: author's elaboration with data from the Brazilian Government, Transparency Portal. Updated expenses as of Feb 2, 2021. Refinancing: payment of principal and monetary correction with revenues from the issuance of new securities. Debt service: payment of interests and amortizations.

Data for public sector spending based on international accounting standards corroborates the argument that the Brazilian case stands out in international comparison

[138] The first approach is used by the Citizen Debt Audit (Fattorelli, 2013) and some heterodox economists, while the second is adopted by the government and another part of the academic community. The central argument for including refinancing expenditures is that the government seems to use accounting gimmicks to mask interest charges as refinancing costs (Fattorelli and Ávila, 2017).

(Figure 4.4). The OECD/UN Classification of Functions of Government (COFOG) uses the indicator "public debt transactions" to compute the financial expenditures of the central government, mostly gross interest expenses on the public debt. The results for Brazil and various country aggregates for the year 2016 reveal that the public debt burden in the country is several times larger than that observed in other emerging and advanced economies – almost twice the Latin American average and three to four times higher than the other regions in 2016. Health spending, in turn, is relatively lower than in any other regional average. Although international comparisons should always be made with caution, Brazil stands well above all other aggregates when it comes to financial expenditures, and well below them regarding health expenditures, suggesting that the results cannot be fully explained by differences in methodologies.[139]

Figure 4.4 Brazil and selected aggregates, central government expenditures with public debt transactions and health, 2016 (% of GDP)



	Brazil	G-20	G-7	Emerging Economies[1]	Emerging Latin America[2]	Advanced Economies[3]
Health	2.0%	3.0%	3.4%	2.5%	2.9%	3.3%
Public debt	9.7%	3.2%	2.7%	2.7%	4.7%	2.0%

Source: author's elaboration based on data from the Brazilian National Treasury (Tesouro Nacional, 2018). Public debt transactions: interest payments and outlays for underwriting and floating government loans. Data for central governments. [1]South Africa, Argentina, Brazil, Bulgaria, Kazakhstan, Chile, China, Hungary, Lithuania, Poland, Russia, Thailand, Turkey, Ukraine. [2]Argentina, Brazil, Chile. [3]Germany, Australia, Austria, Belgium, Singapore, Denmark, Slovakia, Slovenia, Spain, United States, Estonia, Finland, France, Greece, Netherlands, Ireland, Iceland, Israel, Italy, Japan, Norway, New Zealand, Portugal, United Kingdom, Czech Republic, Sweden, Switzerland.

To end, we can apprehend the role of the Unbinding of Union Revenues (DRU), the rule that withdraws funds from the Social Security system, in supporting this regime, as well as its impacts on health financing (Table 4.9). Following the same methodology to calculate the Social Security budget items presented earlier in this chapter (Table 4.2), one can see that the volume of revenues channeled from the Social Security to the fiscal budget via DRU rose almost every year over the past decade, from R$65.6 billion in 2005 to R$120.2 billion

[139] In our case, the limits for comparison using COFOG indicators relate to the fact that they consider only central government expenditures. However, depending on the country, local administrations might have an important weight in the financing of health care and (more rarely) of public debt.

in 2018.[140] The DRU unbound a total of R$1.1 trillion from the Social Security budget in this period. The final balance of the Social Security budget (revenues net of expenditures, presented in Table 4.2) was significantly lower than the revenues withdrawn via DRU each year. This suggests that the system would not have "deficits" during most of its recent history if it were not for this device. The value disconnected by the DRU was almost equal to federal spending on health, which totaled R$1.3 trillion.

Data also indicate that the funds appropriated via DRU played a fundamental role in achieving budget targets, and therefore servicing the public debt. The table shows that Brazil had fiscal surpluses until 2013, and that the amount diverted by this device was equivalent to 66% of the annual fiscal surplus on average. This proportion is sufficiently large to confirm the importance of the DRU in achieving these results. When the federal government's accounts began to present negative results in 2014, the DRU continued to channel significant amounts of funds to the government budget, preventing even larger deficits.

Table 4.9 Brazil, Unbinding of Union Revenues (DRU) and selected indicators of federal government accounts, 2010-2018, billions of reais of 2018

	Social contributions unbound via DRU	Health expenditures	Primary fiscal result	Interest expenditures
2005	65.6	73.7	113.2	262.8
2006	65.9	77.9	101.0	229.9
2007	72.3	74.2	113.0	203.3
2008	69.4	77.1	126.9	191.9
2009	65.8	82.6	73.1	258.7
2010	73.7	87.6	127.3	228.4
2011	79.0	94.3	140.9	302.8
2012	82.9	100.3	123.9	250.8
2013	85.6	102.3	103.4	293.9
2014	80.0	107.8	-25.8	346.7
2015	70.7	106.5	-132.9	490.8
2016	106.3	105.8	-169.8	346.2
2017	118.1	105.7	-122.6	402.4
2018	120.2	107.9	-115.6	386.0
Total (2005-2018)	1,155.6	1,303.7	-	4,194.7

Sources: author's elaboration. Data for DRU, ANFIP (2019); for health expenditures, Tesouro Nacional (2020); for interest expenditures, Banco Central (2020b). Values for the federal government only. Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Average exchange rate of Dec. 2018: 4.3 Reais/Euro.

The role of financial institutions

Another way to articulate the process of financialization with the monetary and fiscal reforms presented above is by showing how financial players have worked to sustain this

[140] Considering that there are different methodologies for computing items of the Social Security Budget (Box 4.1), there are also different values for the volume of resources withdrawn via DRU. Yet, the impacts of the DRU over Social Security accounts are significant even when adopting the more conservative methodology used by the National Treasury Secretariat. Following the latter approach, one can still see that the sum of revenues unbound by the DRU corresponded to around two-thirds of the Social Security deficit in 2007-2016 (STN, 2017).

policy framework and profit from it. There are compelling reasons to argue that the regime in place allowed financial actors to gain influence over the State's decision-making processes and boosted financial accumulation, two defining features of financialization.

As in other countries, it is difficult to be precise about the identity of the actors holding public debt securities and profiting from interest payments, protected by confidentiality agreements and the complexity of financial markets. Even policymakers have attempted, so far unsuccessfully, to make this information publicly available (Senado Federal, 2015). Despite transparency issues, aggregate data for the public debt market show financial institutions are the agents that participate more actively and profit the most from these operations. There are twelve "primary dealers" of the public debt in Brazil – institutions with preferential access to the Treasury auctions and privileged position to purchase and trade government bonds. They consist of large banks and brokers, mostly private, some associated with foreign capital. Examples include Bank of America/Merrill Lynch, Goldman Sachs, Credit Suisse, Santander, Bradesco, and Itaú (Tesouro Nacional, 2019a). Financial institutions also hold the largest part of the outstanding public debt. In 2018, approximately 75% of public debt bonds were in the hands of banks, investment funds, and pension funds (Tesouro Nacional, 2019b).[141]

It might be argued that these financial institutions operate with public securities on behalf of citizens, rather than for themselves. Even when this is the case, only a small and wealthy share of the population benefit from financial market operations. According to estimates from the Brazilian Financial and Capital Markets Association, 3% of Brazilian investors held public bonds and 9% participated in investment and private pension funds in 2018 (ANBIMA, 2019a).[142] Data from the same institution also suggest that, the wealthier the individual, the higher the proportion of his or her investments allocated to financial assets (such as bonds and shares) relative to savings deposits (ANBIMA, 2019b). This confirms that the vast majority of the gains made in financial and capital markets are appropriated by the upper stratum of the population. Also, the National Treasury Secretariat mentions 786,000 investors buying public bonds directly via the *Tesouro Direto* platform in 2018 (Tesouro Nacional, 2019b), which accounts for less than 3% of the total population.

Apart from their roles as intermediaries and public debt investors, financial institutions also wield power over the Brazilian macroeconomic regime due to their capacity to influence the level of the domestic interest rates. In doing so, they can influence the remuneration of a large part of their portfolio (including the assets they hold and the loans they provide), as well as of their clients. Therefore, they have incentives to push for higher rates as well as to keep the macroeconomic policy regime in place, as it prioritizes the saving of funds for interest payments.

Bresser et al. (2019) identify two key channels through which financial institutions and investors can influence interest rates in Brazil. The first one is during the process through which the Central Bank decides on the level of the basic interest rates to reach the inflation target. The opinion of financial institution analysts is one of the elements taken into account

[141] Data for the Internal Federal Public Securities Debt.
[142] According to the same source, 5% invested in private securities.

by the monetary authority, a practice that is openly acknowledged by the latter. The second main channel is during public debt auctions. Especially in times of economic distress, financial actors would take advantage of their bargaining power and demand higher interest rates to finance the government. This and several other studies (Bruno et al., 2011; Modenesi, 2011; Oreiro and Passos, 2005; Weisbrot et al., 2017) argue that such a configuration encourages financial institutions to adjust their behavior, pushing for higher interest rates. This is facilitated by the fact that the domestic banking sector is highly concentrated.

This description concludes our analysis of how monetary and fiscal policy shifts that favor the process of financialization have impacted SUS financing. We have demonstrated that financialization affected the long-term financing of the PHS through the adoption of inflation targets and permanently high interest rates to reach them. This policy framework served as a fundamental engine for financial accumulation in Brazil while imposing sharp restrictions on public spending. We showed that the federal government advanced measures in both the fiscal and the Social Security budget to save public revenues for interest and amortization payments, thereby sacrificing resources that could go to SUS. The prioritization of financial over health expenditures is clear; health spending evolved at a much slower pace than financial expenditures since the 1990s, in a country with the largest universal health system in terms of population coverage.

This macroeconomic regime has been diverting SUS' existing and potential revenues toward public debt investors almost since the system's creation, and over two decades. In the next sections, we will explore how financialization has also reshaped what happens in the short-term financing of the PHS.

4.3.2. Investing SUS revenues in short-term financial assets: policies at the subnational level

This section examines our second dimension of financialization, considering how this process rewires SUS' short-term financing circuits – i.e., the financing of current expenditures within the fiscal year. The central mechanism of financialization identified in this case is the use of SUS revenues to undertake short-term financial investments. This is done by State and Municipal Health Funds, the entities in charge of managing SUS revenues at the subnational level. These investments can be interpreted as a form of financialized fiscal policy to the extent that public health bodies engage with financial instruments to manage their revenues. They can also be linked to the previous mechanism in that they serve as a way for these bodies to try to cope with the budget constraints they face by seeking investment returns.

To understand how SUS revenues can be invested in financial instruments, we will describe the role of Health Funds and the evolution of the legal framework allowing them to engage with financialized practices. Concerning data analysis, there is neither a national database providing detailed information on the investments carried by the Health Funds nor a standard format for the latter to present such information. These limitations make it almost impossible to gather information about financial investments at the national level (including 26 states, the Federal District, and more than 5,500 municipalities). Therefore, we will

conduct an empirical analysis on the subject using data for Rio de Janeiro and the Federal District, the country's former and current capital, respectively.[143]

The role of Health Funds

The 1988 Constitution determined that the resources destined for public health actions and services should be applied through Health Funds (Brazil, 1988, art. 77 ADCT). A Health Fund is strictly defined as a set of accounts through which each government in Brazil receives revenues and executes expenditures related to health actions and services. Each government has its own Health Fund – including the federal government, each state and local government, and the Federal District government. In practice, the term "Health Fund" is commonly employed to refer to the public body in charge of administering these accounts. At the federal level, the Ministry of Health controls the National Health Fund. At the subnational level, State Health Secretariats, bodies from the state governments, control the State Health Funds. The same goes for municipal governments and their Municipal Health Secretariats, which control Municipal Health Funds.

SUS financing circuits are organized around the Health Funds (Figure 4.1); in principle, all revenues allocated to health actions and services in each unit of the federation should be placed in its respective Health Fund, and all expenditures incurred to pay for these actions and services should originate from the latter.[144]

Health Funds were created as tools to improve SUS financing and oversight. They allow governments to gather revenues from various sources and centralize them in a single pool. This was considered important to optimize decision-making processes and resource allocation. In addition, having an entity dedicated exclusively to health-related revenues and expenditures was seen as fundamental to improving transparency and accountability. They would make it easier for public authorities and civil society to track the sources, volume, and final destination of funds allocated to SUS.

State and Municipal Health Funds can place their revenues in financial assets for a short period of time before allocating them to public health actions and services. These investments must be highly liquid, which includes savings deposits, bank certificates of deposits (CDBs), and short-term investment funds.[145] The main justification presented by the public administration for carrying short-term investments is because the Funds do not disburse the revenues they receive all at once, but pass them on to different public and private entities in charge of health actions and services along the upcoming weeks and months. In this context, investing in short-term financial assets would allow them to preserve and increase the value of their revenues by yielding returns and monetary restatement

[143] See Appendix 2 for further information on the data sources and treatment.
[144] Governments are yet to fully obey this rule, but the violations have been falling significantly.
[145] Bank certificates of deposit (Certificados de Depósito Bancários, CDB) constitute a popular type of short-term investment in Brazil. They are often presented as a form of investment in which individuals "lend money to banks". Banks issue CDBs and repay the purchaser with the amount invested plus interest payments based on an interest rate agreed in advance. They are, therefore, a fixed income security. Their maturity terms usually range from one month to five years and they can be redeemed before the end date. CDBs represent an important source of funds for the Brazilian banking system.

(compensation of losses due to inflation) while these are not applied to health actions and services (Junior et al., 2013; SNA, 2012; TCU, 2010).

SUS' founding regulatory framework (the Federal Constitution of 1988 and the 1990 Organic Health Laws) does not mention the possibility of using the system's revenues to carry financial investments. During most of the time since the 1990s, Health Funds did so based on lax legislation predating the system's creation. This legislation regulates the activities of the so-called "special funds", a broader category of the Brazilian public administration to which they belong.

The concept of "special funds" was introduced by the military government in the 1960s (Brazil, 1969, 1964). They consist of budget units dedicated to managing public resources for a specific public policy program or goal. There is a wide range of special funds in Brazil dedicated to financing specific activities in several areas. Three features distinguish special funds from other types of entities within the public administration: (i) they are endowed with specific sources of revenues; (ii) these revenues are tied to the execution of activities with a predefined purpose established upon their creation; and (iii) they have the autonomy to establish their own norms for managing these revenues.

The prerogative to freely manage their resources grants Health Funds the possibility to make financial investments. Sanches (2002), who studied the legislation in detail, concludes that special funds can raise revenues from any source that does not violate the prohibitions established by the 1988 Constitution. The author identifies a number of the most common sources of income used by them, which include (i) earmarked taxes, (ii) fees, contributions, and other forms of public revenues, (iii) government allocations, and (iv) other funding sources. The latter item encompasses returns from the investment of their revenues in financial markets.

The federal government created the National Health Fund (FNS) in 1969 as a special fund to finance programs carried out by the Ministry of Health. With the creation of SUS in 1988, the National Fund became the central entity in charge of managing the revenues that the federal government allocated into the system. State and Municipal Health Funds (FES and FMS, respectively), in turn, were special funds born together with SUS. The 1988 Constitution and the 1990 Organic Health Laws determined that the system's resources should be deposited "*in a special account in each sphere of operation*" (Brazil, 1990a, art. 33), obliging subnational governments to create special funds for this purpose. Most subnational Health Funds were created during the 1990s (Pereira, 2013). The wave of creation of Health Funds across the territory was strongly driven by rules enacted in this period preventing state and municipal governments from receiving federal funds for SUS in the absence of a Health Fund (Brazil, 1994, 1990b).

Instead of being subjected to nationwide legislation, each subnational government was left to make its own laws to set up its Health Fund. Due to its status as a special fund, each government could freely determine its sources of income. This served as the gateway for investments in financial markets. The thousands of state and municipal laws instituting Health Funds often include the item "*income and interests from financial investments*" in the list of potential revenues. During most of the time since the creation of subnational Health

Funds, this was not foreseen in SUS legislation. Public bodies most often referred to legislation on special funds dating from the 1960s to justify the practice (SNA, 2012).

Another set of laws that provided (questionable) legal grounds for investing in financial assets relates to the regulation of intergovernmental agreements. In these types of agreements, different governments work together to finance public projects and programs. They can be used in several areas (including, but not limited to, health). The monetary transfers from the federal sphere to state and local governments in the context of intergovernmental agreements are subject to specific regulations. In the early 1990s, the federal government determined that revenues from agreement transfers should be mandatorily applied *"in savings accounts of official financial institutions if their use is foreseen to be equal or superior to one month"*, or *"in short-term financial application funds or open market operations backed by public debt bonds, when their use will take place in less than one month*" (Brazil, 1993). There is no specific reference to SUS or health-related agreements in these laws. Moreover, a minor share of federal revenues received by Health Funds derives from these types of contracts. Even so, public entities have also mentioned the referred law when justifying the application of SUS revenues in financial investments (Bolzan, 2010).

SUS regulatory framework remained oblivious to the practice of financial investments until the mid-2000s. The absence of any specific regulation up to this point is surprising considering that the Brazilian legislation is loaded with special rules for health-related revenues and expenditures (section 4.1.2). This loose legislation, coupled with the unequal capacity of the more than five thousand State and Municipal Health Funds in Brazil to invest in the markets, led the practice to expand unevenly and with little transparency.

Starting in the mid-2010s, the regulation regarding financial investments underwent significant shits. For the first time, the federal government introduced the practice in the legal framework governing SUS. The earlier reference to financial investments within SUS legislation seems to date from 2014.[146] In an ordinance signed this year, the Ministry of Health determined that the resources from the federal government addressed to State and Municipal Health Funds should be invested in savings or short-term investment funds until they could be allocated to health actions and services. The rule concerns resources from fund-to-fund transfers, which provide most of the revenues coming from the federal government.[147] Also, these investments became mandatory instead of depending on the decisions of each Fund. As provided for in the new rule,

[146] As concluded from our searches in the archives of the Chamber of Deputies, the Federal Senate, and the Health Ministry (available at www.camara.leg.br, www.senado.leg.br, and www.saude.gov.br/saudelegis), as well as from our examination of the preceding legislation listed by the laws mentioned in this section.

[147] Federal transfers to state and municipal Health Funds are divided into "fund-to-fund transfers" and "agreement transfers". Fund-to-fund transfers are mandatory (the Constitution obliges the federal government to provide them), paid on a continuous and regular basis, and have a minimum predefined value. They serve to cover operating and capital expenditures. Agreement transfers are voluntary (they depend on agreements signed between the federal and a given subnational government), do not have defined periodicity, and the values vary according to the project or activity in question.

> The **costing resources transferred by the National Health Fund** to the Health Funds of the other federative entities in the "fund-to-fund" modality, while not used for the purpose for which they were transferred, **will be mandatorily invested** in a federal public financial institution, through the account opened by the National Health Fund, as follows:
>
> I - **in a savings account**, if the expected use of the financial resource is equal or superior to one month; and
>
> II - **in short-term financial investment funds or open market operations** backed by public debt securities, when its use is expected for a shorter period than that stipulated in item I (Brazil, 2014, art. 6-C, emphasis added).

The federal government reinforced this rule in 2017, approving a new law that turned the investments not only mandatory but also automatic. The government determined that the resources coming from fund-to-fund transfers should be directly placed in financial assets. The Fund managers were responsible for the subsequent administration of these resources, deciding on whether they should remain in short-term investments or be transferred to a savings account. This was imposed in the following terms:

> § 1 The resources that make up each financing block will be transferred, fund to fund, on a regular and automatic basis, in a specific and unique current account for each block, held at official federal financial institutions (....)
>
> § 4 While they are not invested for their intended purpose, **the resources referred to in this article shall be automatically placed in short-term financial application funds**, backed by federal public debt securities, with automatic redemptions (Brazil, 2017, art. 3, emphasis added).[148]

The idea that this practice grew in a regulatory gray area finds further support when looking at the way in which the federal government included these rules into SUS legal framework. Both the 2014 and 2017 legislations mentioned above were amendments to laws that did not mention financial investments in the original text. The 2014 ordinance is an amendment to an administrative act approved three years earlier to regulate transactions between the federal government and state and municipalities, with no reference to financial investments. Surprisingly, not even the 2014 rule itself focused on investments. Its main purpose was to regulate cash transfers from SUS to individuals under extraordinary circumstances. The article mandating the application of federal revenues in financial instruments by subnational Health Funds was appended as the last item of the text.

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[148] The legislation in question and the own Health Secretariats employ the expressions *aplicações financeiras* and *fundos de aplicação financeira*, which we translate into "financial applications" and "financial application funds", respectively. We could not find a technical definition for such expressions in public accounting manuals. Based on empirical research, this category seems to include short-term financial instruments such as CDBs (see footnote 145) and quotas of short-term investment funds. In the context of Health Funds, we will consider financial applications as any form of pooling and investing resources apart from holding them in savings accounts. We avoided translating the term *fundos de aplicação financeira* to "financial investment funds", a more common term in English, because instruments such as CDBs do not fit perfectly into this category. When possible, we will adopt the terms "financial instruments", "financial assets", and "financial investments", due to their most common usage in English. These expressions will be used to refer to both savings deposits and the so-called "financial applications" (CDBs and quotas of investment funds).

Likewise, the 2017 rule is not an original act regulating financial investments but a rule enacted to alter a previous norm on a different topic. The initial norm established that federal transfers would be organized into six spending categories ("financing blocks"). The new ordinance reorganized this model by dividing federal transfers into two categories only, for current expenditures and investments. Among many items regulating the revised model for federal transfers, there was the item mentioned above, establishing the automatic and mandatory investment of these revenues in financial assets. The lack of legislation specific to the topic suggests that these policy changes were implemented without giving the civil society and other stakeholders in SUS the opportunity to debate on whether these practices should be allowed.[149]

The legislation is highly heterogeneous concerning the nature of the banks where Health Funds should hold accounts to receive federal revenues. The uncertainty is even greater when it comes to the institutions where they can invest the latter. For example, the 2017 law reorganizing Health Funds' accounts into two spending blocks specifies that each block must have a dedicated bank account, opened at a public bank (*Caixa Econômica Federal,* the Federal Savings Bank) or a mixed economy bank (*Banco do Brasil,* the Bank of Brazil). Other laws regulating SUS operations present different specifications as to the nature of the financial institutions involved in the concerned action.[150] Still, the legislation generally refers to the financial institutions where the Health Funds should be received, not where they should be invested. As we will see in our empirical investigation, State and Municipal Funds end up engaging in financial operations in both public and private for-profit institutions.

The undertaking of financial investments by State and Municipal Health Funds has attracted little scholarly attention so far. To our best knowledge, the only published work examining the practice is Bolzan (2010), who found evidence of this practice in the context of a broader study on the financing of public health activities in the state of Rio Grande do Sul during the 2000s. Inspecting the accounts of the state's Health Fund, the author observed an increasing volume of revenues invested in financial instruments, namely in CDBs. According to his calculations, the amount of revenues from the State Health Fund invested in financial markets grew from R$77 million in 2006 to R$306.5 million in 2009.[151] The author underscores the relevance of these results, as the accumulation of revenues in financial markets means that at least part of them was not being disinvested in due time to finance public health actions and services.

In the following section, we attempt to broaden this quantitative perspective by focusing exclusively on the undertaking of financial investments by two Health Funds in a more recent period, and discussing how they connect with the concept of financialization.

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[149] This seems to corroborate what Bahia et al. (2016) have observed when describing the evolution of the regulatory framework for private health activities in Brazil; the national legislation often comes to regulate practices already in place but which lack legal support. The influence of vested interest groups is presented as an important factor driving these regulatory shifts.

[150] See, e.g., federal ordinances 3,925/1998, 1,749/2002, 412/2013, decree 7,507/2011, and complementary law 141/2012.

[151] Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA), R$38 million and R$152 million in nominal values. Average exchange rate of 2018: 4.3 Reais/Euro.

The Rio de Janeiro State Health Fund

The Rio de Janeiro state (ERJ) has the second largest GDP among all Brazilian states, accounting for more than one-tenth of the national output in 2018. It is also one of the most populous states, with over 17 million people (IBGE, 2020a, 2020b). The severe economic crisis of the mid-2010s was a shock to the state's already fragile accounts, diminishing its participation in the Brazilian economy in more recent times. Rio de Janeiro suffered one of the largest drops in revenues and economic growth rates during the second half of the decade, along with one of the sharpest rises in public debt levels (FIRJAN, 2017; Silva, 2017).[152] In 2016, the governor in office declared a state of public calamity in Rio's financial administration, imposing harsh measures such as the rationalization of essential public services and postponing payments to civil servants and suppliers (Rio de Janeiro, 2016).

The ERJ has approximately thirty special funds, among which there is the Rio de Janeiro State Health Fund. The law creating this Fund dates from 1989 and includes income from investments among its potential sources of revenues. It states that "*the following shall constitute revenues for the Fund: (...) VI - revenues, increases, interests, and monetary restatements resulting from the investment of its resources*" (Rio de Janeiro, 1989).

The Health Fund has a significant weight in Rio de Janeiro's state finances. In 2018, it received almost 30% of the revenues allocated to the 24 special state funds with data available for that year (Rio de Janeiro, 2020). The ERJ Health Fund is often cited in government financial statements as one of the state funds with the largest amounts of revenues under management as well as some of the largest volumes of resources invested in "financial applications".[153] The government's 2014 year-end report, for example, indicates that the Health Fund was responsible for more than 15% of the money invested in applications in that year, all state funds combined. It also had 90% of the total amount allocated in savings accounts (SEF-RJ, 2015). Likewise, the 2016 report listed the Health Fund as the state entity with the third largest volume of money allocated in financial investments (SEF-RJ, 2017). Last, the 2018 report shows that the Health Fund was the special fund with the third largest amount of cash and the highest volume of revenues held in savings accounts in the state (SEF-RJ, 2018).

The table below systematizes the value of financial investments by Rio de Janeiro's State Health Fund from 2012 to 2018, using figures obtained directly from the State Health Secretariat (Table 4.10). The data suggest that the Fund had a relevant amount of resources allocated in financial assets until the economic crisis, with over R$740 million invested in 2012. After dropping together with the deterioration of state finances, investments started to recover in the last years of the series to reach nearly R$150 million in 2018.

The returns on investments fell in 2012-2016 along with the reduction in the value of money placed in those instruments. Despite the recovery of investments at the end of the series, the reported returns continued to fall. These went from around R$40 million per year at the beginning of the series to a value ten times lower in 2018, of R$4 million. The drop in

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[152] Rio de Janeiro's GDP grew by an average of 2.5% p.a. in 2010-14, followed by a -2.9% p.a. contraction in 2015-17 and a modest recovery of 1.3% p.a. in 2018-19 (IBGE/FIRJAN).
[153] See footnote 148.

the volume of invested cash in the middle of the series is most certainly linked to the state's financial turmoil and economic recession, which probably led to a greater withdrawal of resources to cover expenditures.

The financial statements provided by the Health Fund Secretariat allow us to break down the share of investments allocated to savings deposits and investment funds. These represented on average 70% and 30% of total investments, respectively. The participation of investment funds followed a pro-cyclical behavior, diminishing in the period of most acute recession (2014-2016). Their relative participation grew substantially in the last years of the series, exceeding 40% of the total amount of revenues placed in financial assets in 2017-2018.

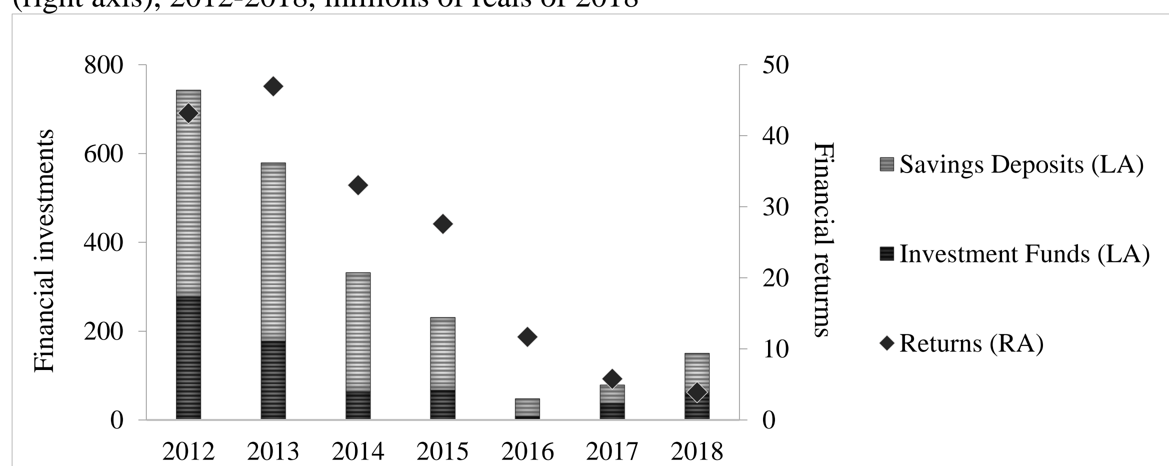
Table 4.10 Brazil, Rio de Janeiro State Health Fund, financial investments, 2012-2018, millions of reais of 2018 and % in total investments

	2012	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*
Millions of Reais of 2018							
Total	742.7	578.8	331.8	230.8	47.8	79	149.9
Savings deposits	*465*	*402*	*268*	*163*	*40.1*	*41.5*	*88.2*
Short-term investment funds	*278*	*177*	*63.6*	*67.5*	*7.8*	*37.5*	*61.6*
Investment returns[1]	43.2	46.9	33	27.6	11.7	5.8	3.9
% Total investments							
Savings deposits	63%	69%	81%	71%	84%	53%	59%
Short-term investment funds	37%	31%	19%	29%	16%	47%	41%

Source: author's elaboration based on data from the Rio de Janeiro State Health Secretariat via the Law of Access to Information. [1]Item "asset variations - remuneration of bank deposits and financial applications". Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Rounded values. Closing balance as of late December. Average exchange rate of 2018: 4.3 Reais/Euro.

Figure 4.5 below uses data from the previous table to better illustrate the evolution of financial applications and the volume of financial returns obtained by the State Health Fund over the past decade.

Figure 4.5 Brazil, Rio de Janeiro State Health Fund, financial assets (left axis) and returns (right axis), 2012-2018, millions of reais of 2018



Source: author's elaboration based on data from the Rio de Janeiro State Health Secretariat via the Law of Access to Information. LA: left axis. RA: right axis. Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Rounded values.

Table 4.11 breaks down the volume of revenues placed in financial instruments according to the nature of the banks holding them. We can observe that the Health Fund had investments in both public and private institutions. In the first case, these were the Federal Savings Bank (entirely public) and the Bank of Brazil (partially State-controlled). In the second case, the banks involved were Bradesco and Itaú, the two largest private for-profit banks in the country. The participation of each category varied according to the type of investments. Public banks held almost the entirety of savings deposits, while private banks had a relatively larger participation in the case of short-term investment funds. The weight of public and private banks in total investments varied throughout the period along with the proportion of revenues allocated to each type of instrument.

Table 4.11 Brazil, Rio de Janeiro State Health Fund, financial assets by nature of institution, 2012-2018, % of investments

	2012	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*
Savings deposits							
Public banks	99.9%	99.9%	99.8%	99.6%	98.5%	98.4%	99.3%
Private banks	0.1%	0.1%	0.2%	0.4%	1.5%	1.6%	0.7%
Short-term investment funds							
Public banks	96.1%	92.1%	90.5%	94.8%	34.3%	84.7%	97.9%
Private banks	3.9%	7.9%	9.5%	5.2%	65.7%	15.3%	2.1%

Source: author's elaboration based on data from the Rio de Janeiro State Health Secretariat via the Law of Access to Information. Results from the aggregation of different accounts in each bank.

The Federal District Health Fund

The Federal District (DF) is home to the current capital of Brazil, Brasília. Apart from being the country's political center, it is also a relevant economic hub. It has the eighth largest GDP among the 27 federative units in the country, amounting to 3.6% of the national GDP in 2018, and the largest GDP *per capita* (IBGE, 2020b, 2020c).[154] The Federal District has a population of 3 million people, and its capital, Brasília, is the third most populous city in the country (IBGE, 2020a). Despite growth rates above the national average during the 2010s, the fiscal crisis in the second half of the decade also hit the region, pushing up public deficits and debt levels. Still, the Federal District remained one of the lowest debt-to-income ratios of the federative units (FIRJAN, 2017). [155]

The Federal District has approximately 32 Special Funds, including the Federal District Health Fund. The Fund was created in 1996, and its founding act foresees income from investments as part of its revenue sources: "*the following constitute revenues for the Federal District Health Fund: (…) III- the returns resulting from the investment of its resources in the financial market*" (Distrito Federal, 1996). Unlike in Rio de Janeiro, the Federal District's government does not publish information comparing the levels of revenues and investments of its different Funds. However, it is safe to say that the Health Fund has a

[154] The Federal District is not officially classified as a state, but as an autonomous territory separated into thirty-three administrative regions. For reasons of simplicity, it is a customary practice to analyze it together with the 26 Brazilian states.

[155] GDP growth rates went from an average of 2.9% p.a. in 2010-14 to negative rates of -0.5% in 2015-16, with a slight recovery to 1% in 2017-18 (CODEPLAN, 2019).

significant weight in government finances. According to the Federal District Court of Accounts, this has received almost 60% of the public revenues that the DF government allocated to special funds in 2018 (TCDF, 2019).

The analysis of the Health Fund's financial portfolio from 2012 to 2018, using information provided directly by the Federal District Health Secretariat, reveals a considerable volume of money invested in banks at the beginning of the decade, starting the series with more than R$770 million in financial assets (Table 4.12). The volume of investments has gradually declined in the period of economic crisis but recovered in the last year of the series, ending at R$517 million in 2018. Investment returns went from R$52 million in 2012 to R$20 million in 2018, following an erratic path over the years. They followed the trends of investments until 2017, after which it is possible to observe a detachment; investments resumed growth, while financial income continued to drop.

The largest share of investments carried by the DF Health Fund was in short-term investment funds, followed by bank certificates of deposit (CDBs) and savings deposits. These averaged approximately 50%, 40%, and 10% of total investments in this period, respectively. The relative participation of investment funds grew significantly in the last years of the series, reaching almost 90% of the amount invested in 2018.

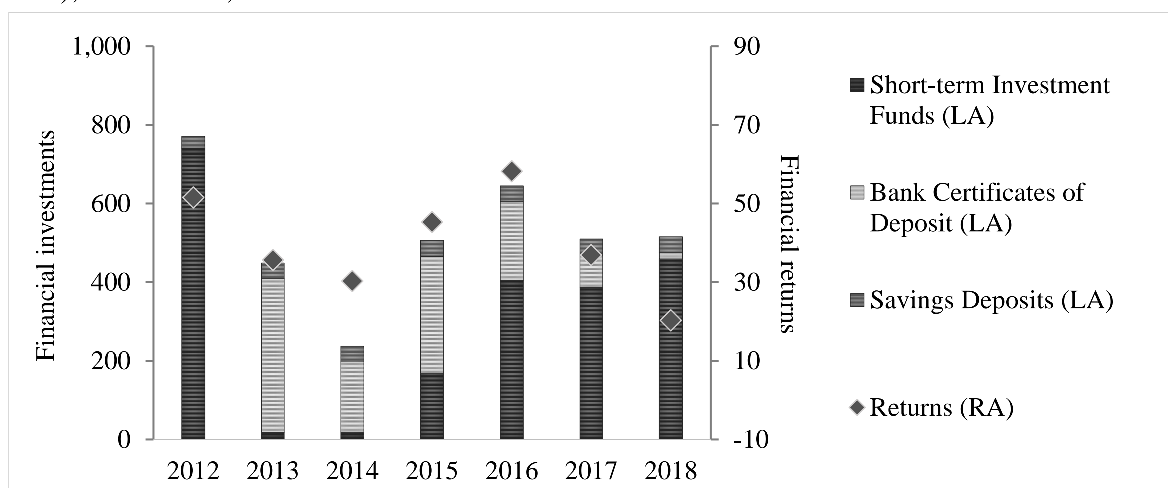
Table 4.12 Brazil, Federal District Health Fund, financial assets, 2012-2018, millions of reais of 2018 and % in total investments

	2012	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*
Millions of Reais of 2018							
Total	771	449	237	506	645	510	516
Savings deposits	*31*	*40*	*40*	*41*	*39*	*41*	*41*
Investment funds	*741*	*18*	*19*	*169*	*404*	*387*	*459*
Bank certificates of deposit	*0*	*391*	*178*	*297*	*202*	*82*	*15*
Investment Returns	52	36	30	45	58	37	20
% Total investments							
Savings	4%	9%	17%	8%	6%	8%	8%
Investment funds	96%	4%	8%	33%	62%	76%	89%
Bank certificates of deposit	0%	87%	75%	58%	31%	16%	3%

Source: author's elaboration based on data from the Federal District Health Secretariat via the Law of Access to Information. Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Rounded values.

Figure 4.6 shows the evolution of investments by type of instrument, both in absolute values and relative to total investments. As for the nature of financial institutions involved, the Federal District Health Secretariat informed that the Fund carried the investments in public institutions.

Figure 4.6 Brazil, Federal District Health Fund, Financial assets (left axis) and returns (right axis), 2012-2018, millions of reais of 2018



Source: author's elaboration based on data from the Federal District Health Secretariat via the Law of Access to Information. RA: Right Axis. LA: Left Axis. Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Rounded values.

Having covered the technical aspects of this financing strategy underpinned by financial instruments, we can now discuss the extent to which this practice forges new relations between Health Funds, on the one hand, and financial markets and institutions, on the other. We can also consider its potential impacts on public provision by examining evidence of "revenue retention" – when SUS revenues remain invested in financial instruments instead of being channeled to health actions and services.

When the financial system overrides the health system: revenue retention practices

When Health Funds place their revenues in short-term financial investments, the sums invested are not registered as expenditures, but remain on the side of revenues. In this way, the use of financial instruments opens a window of opportunity for public entities to keep SUS revenues in the financial system; withholding resources in financial assets would allow the Funds to improve their financial statements, preserving revenues and bringing in extra income from returns on investments. The practice through which Health Funds maintain resources in financial instruments during an extended period of time is known as "resource retention" (*contingenciamento de recursos*). The key problem associated with this practice is that it reduces the amount of revenues actually invested in health actions and services, with detrimental effects on the quantity and quality of SUS provision.

The Brazilian Federal Court of Accounts itself has acknowledged that Health Funds may engage in this practice:

> Legally, the fund manager is encouraged to invest the money received through the funds in the financial markets, as long as it is invested ahead of the deadlines for using the money. However, unfortunately, there are cases in which the managers keep the money in financial applications to

obtain financial income (TCU, 2010, p. 70).

The challenges for obtaining information on the financial investments carried by Health Funds make it virtually impossible to investigate the possibility of revenue retention publicly accessible data. Moreover, neither the federal nor subnational governments organize systematic auditing processes by external bodies to monitor the timely divestment of these revenues so they can be addressed to health actions and services. It is, nevertheless, possible to examine this practice by gathering qualitative information from policymakers' statements and audit works for different states and municipalities across the country.

A first piece of evidence regarding resource retention comes from the city of Rio de Janeiro, the capital of the homonymous state examined in the previous section. According to a statement by a then-senator, later mayor of the city during a meeting in the Legislative chamber, leaving the resources earmarked for health expenditures in financial markets for long periods of time was a customary practice in the country by the mid-2000s. The speech took place during a debate about the degradation of health services in Rio de Janeiro observed at this time. Its content suggests that the practice of resource retention has contributed to the critical situation. Reproducing it *verbatim*,

> There is a very harmful practice that, nowadays, in the 5,561 municipalities of our Brazil, is becoming commonplace. In the first, second, and third year, the mayor reduces expenditures and applies the resources from health and education (...) **making a quarantine for this money to pass through financial markets before, so that in the last year he has enough money** (...)
>
> Your Honor can see Rio de Janeiro's budget, where, in the first three years, spending levels were reduced, and **the largest [source of] income was not the tax on services, the urban property tax, or the Municipal Participation Fund, but returns on financial investments** (Senator M. Crivella's speech on March 24, 2004, retrieved from Senado Federal, 2020, emphasis added).

Press reports released around the same time also drew attention to the issue of resource retention. Nery (2005), for example, describes the results of the auditing work conducted by the Ministry of Health in the Rio de Janeiro Municipal Health Fund in 2004-2005. According to the information released to the press, the auditors found R$30 million worth in financial investments in the Health Fund.[156] Both auditors and journalists called attention to the contrast between, on the one hand, the high volume of funds earmarked for public health kept in banks, and, on the other, the local government's steady buildup of health-related debts (see also Fortes, 2010; Karpov, 2015).[157]

Looking at the state of Rio de Janeiro, data presented in the previous section show that the state Health Fund kept a significant volume of resources in financial investments

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[156] Nominal values equivalent to approximately R$60.5 million in values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA), or €14.1 million according to the average exchange rate of 2018 (4.3 Reais/Euro).

[157] Both the statement and the report mentioned here refer to the city of Rio de Janeiro. There is no *a priori* reason why this could not apply to the state and other regions as well.

over the 2010s decade. It also suggests that this volume grew since 2016. This stands in stark contrast with the fact that the state's public health network has progressively deteriorated during the decade, collapsing at the very end. Oversight authorities affirm that the state government failed to meet the minimum health spending targets defined by the Constitution during the second half of the 2010s, and that the value allocated was lower each year. In 2016, Rio de Janeiro had the lowest share of government revenues applied in health among all Brazilian states, and government debts with health-related activities accumulated to where it became the area of the public administration with the highest indebtedness levels (MPRJ, 2018). In 2017, the Regional Council of Medicine declared a state of technical calamity in the local public health system due to the shortage of resources to keep it in operation (CREMERJ, 2017).

The paucity of data makes it impossible to verify if the Rio de Janeiro's State Health Fund has engaged in practices of revenue retention during the period under analysis. Still, the existence of revenues held in financial assets, on the one hand, and the growing financing needs of the health system, on the other, suggests that financialized strategies deserve far more attention than they currently receive.

Besides the potentially detrimental effects on service delivery, the case of Rio de Janeiro also shows how the engagement with financial instruments can undermine transparency and social control in the use of SUS revenues.[158] Even official oversight authorities face challenges to obtain detailed, updated information on the Funds' operations. To cite one telling example, the Rio de Janeiro State Prosecutor's Office reported difficulties in examining the management of resources by the state Health Fund because much of the data obtained by the institution was outdated, could not be fully accessed, or presented conflicting values. The lack of transparency naturally extends to financial investments. That they are spread over several institutions and different types of assets makes it even more difficult to collect information. When asked to provide information to the Prosecutor's Office, members from the private bank that manages the Health Fund's central account denied the request alleging the right to "bank secrecy" – even though, as noted by the auditors, the transactions involve public money (MPRJ, 2018).

Differently from Rio de Janeiro, the Federal District's Health Fund has been the object of official investigations into possible retention practices. Research conducted by SUS' audit department found a progressive accumulation of resources in financial assets during the second half of the 2000s. According to the final audit report published in 2012,

> It was found that the SUS manager in the Federal District chose to invest the resources of the Unified Health System (SUS) in bank certificates of deposit, in the financial markets, to the detriment of the offer of health actions and services to the population. At the end of 2006, the amount of resources invested in the financial markets was of R$63.9 million; at the end of 2007, they were of R$124.3

[158] The idea of "social control" is used here to suggest the capacity of the society to control State actions.

> million; on March 31, 2009, the Health State Secretariat had R$238.4 million yielding interest and monetary restatement (…) (SNA, 2012, p. 45).[159]

The audit work also finds that, in several accounts dedicated to specific programs within the Federal District's Fund, the volume of revenues received in a given year was less than the amount allocated in financial investments. This finding is relevant as it illustrates how financial investments may undermine SUS service provision; in 2006, for example, the value of financial investments in the account dedicated to HIV treatments was more than twice the volume of revenues received from the Ministry of Health in the same year to finance such activities. The study also found similar evidence in the accounts dedicated to finance actions related to pharmaceutical assistance, mobile emergency care services, and family health programs. Considering this evidence, the auditors argued that financial investments ended up having a direct and negative effect on public provision. According to them, SUS revenues were kept invested in financial assets to increase returns, "*financially benefiting the fund manager (…) [while] causing irreparable social harm to the users of the Unified Health System*" (SNA, 2012, p. 45).

Also in this case, the recovery of financial investments of the Health Fund in the more recent period, examined in the previous section, is at odds with the detrimental state of public health provision in the region. Public health services in the Federal District have been continuously underfinanced over the 2010s, to the point the government declared a state of emergency in the local public health network by the middle of the decade (Distrito Federal, 2015). Then again, however, there is limited data to be precise over to what extent rising financial investments may have contributed to diminishing investments in public health services. Public databases fail to provide uniform, up-to-date, easily workable information on the institutions and instruments in which the resources are invested, the volume of returns, and the length of investments, to cite a few.

It is worth noting that the potential retention of SUS revenues in the financial sector is not limited to the cases above. In the late 2000s, SUS Audit Department inspected the financial operations of several State Health Funds and found evidence of retention in many of them (Fortes, 2010).

What our case studies can safely demonstrate is that the financial investments could not guarantee an increase in revenues significant enough to justify the practice. They were not able to improve the quantity and quality of health service delivery, which deteriorated in both cases studied here. In contrast to the controversial implications for the materiality of health care delivery, these investments were unquestionably beneficial for financial institutions. When the regular and secure income streams from government transfers to the public health system are automatically directed to the purchase of financial assets, they become an important source of liquidity for the financial sector. The following passage from Bolzan's (2010) case study corroborates this argument. It illustrates how the financial

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[159] Nominal values equivalent to R$125 million, R$234 million, and R$416 million in 2018, respectively, adjusted for inflation according to the IPCA. Average exchange rate of 2018: 4.3 Reais/Euro.

investments carried by the Rio Grande do Sul State Health Fund have benefited banks the most:

> The federal resources transferred by the Ministry of Health and that were invested in bank certificates of deposit (...) **were used to generate more fluidity and liquidity to the banking institution (...) allowing the excess money to be lent to a financial institution** (…). The manager chose to invest the fund-to-fund resources in the financial market to the detriment of the actions to be carried out with the values transferred by the Ministry of Health.
>
> It is interesting to observe that **the federal resources from SUS [were seen] as excess or surplus resources, which allowed such resources to be lent to banking institutions that have a shortage of resources for their operations and financial commitments in order to have more liquidity, to the detriment of users of the public health system.** The "liquidity", or "fluidity" of SUS, with its services, flows, referrals, and counter-referrals, is clearly less important for those who choose to invest SUS federal resources in the financial markets instead of in SUS itself. SUS' financial ballast ceases to exist to ensure that of the financial sector (Bolzan, 2010, p. 81, emphasis added).

This section examined changes in the short-term management of SUS revenues. We focused on the fact that the public entities which administer the system's revenues at the subnational level have been investing their incoming funds in financial assets before allocating them to health actions and services. We can identify links with the process of financialization to the extent that the expansion of financial instruments and actors created opportunities and incentives to change the forms of managing SUS resources. We noted that Health Funds have been using financial instruments since the 1990s to prevent their revenues from losing value in the context of inflation and obtain investment returns. Even more, we emphasized that this practice received a major boost in the 2010s decade, when new rules rendered investments mandatory and automatic. We also highlighted that the same opportunities that enable increased revenues from investment returns also paved the way for resource retention practices, when the revenues remained invested in the financial sector instead of being used to finance health actions and services. We will end this chapter by examining how public health providers, in this case non-profit hospitals working for SUS, have also been integrated into new financing strategies dependent on financial instruments and institutions.

4.3.3. Subsidized credit lines for SUS providers

The process of financialization can also be observed when looking at the changing ways through which the government financed SUS services providers since the late 1990s. Our third mechanism of financialization consists of the deployment of government strategies to finance non-profit hospitals working for SUS based on bank credit. These strategies target, more specifically, philanthropic hospitals, which play a crucial role in the delivery of services on behalf of the public system. We will show that the creation of hospital credit lines was subsidized by public revenues, including those earmarked to finance SUS services.

In this way, public services provided the basis for the creation of financial assets and their collateral.

After describing the role of philanthropic establishments within SUS and their indebtedness process over the past decades, we will examine financialized approaches conceived by the federal government seeking to ease this financial distress. We will trace the evolution of the legal framework regulating hospital bank credit and use data for the most important hospital credit modality, consigned loans, to examine this practice. Our discussion considers how this hospital financing strategy based on bank credit reshape relations between the public system, non-profit providers, and financial institutions, as well as the potential consequences for public service provision.

There is no national database providing information on lending operations to philanthropic health institutions. This prevents us from obtaining figures for the total value of loans and other information covering all the hospitals and financial institutions engaged in this practice. To overcome this challenge, we will combine available information from two sources: the national representative body of philanthropic hospitals (Confederação das Santas Casas de Misericórdia, Hospitais e Entidades Filantrópicas, CMB), which provides data on hospital debt; and the National Health Fund database, from which we can derive the volume of SUS revenues used to repay bank loans.[160]

SUS and the philanthropic health sector

The Brazilian philanthropic health sector comprises several types of private non-profit health establishments, including clinics, hospitals, and basic health care units.[161] Health care philanthropy has a long trajectory in Brazil. The first "Holy Houses" (*Santas Casas*), medical assistance centers associated with religious organizations, date from the 16th century, and some of them are in operation up to this day (CMB, 2016). According to data organized by the Brazilian Senate, there were approximately 5,570 non-profit health establishments in the country in 2018, among hospitals, clinics, and other types of providers. This included around 1,800 hospitals, most of which working partially or exclusively for the public system (Senado Federal, 2018).

Before the creation of SUS in 1988, philanthropic establishments represented the main gateway to medical assistance for those excluded from the public network run by the Social Insurance system (section 4.1). By serving low-income individuals and informal workers, the sector has played a role, however limited, in mitigating social inequalities in health. Philanthropic providers also had a relevant role within public provision, not least as an important part of the services offered by the Social Insurance system was delivered by non-profit institutions, contracted and paid directly by the State. Given these varied roles,

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[160] See the Appendix 2 for further information on the data sources and treatment.

[161] The Brazilian legislation uses different expressions to refer to the philanthropic health sector (see Senado Federal, 2018). In this thesis, we are referring to establishments that fit into the category of "philanthropic institutions", governed by laws no. 12,101/2009 and 13,650/2018. We do not include the private entities identified as the "third sector", such as the "social organizations", governed by laws no. 9,637/1998 and 9,790/1999. The latter operate under a different logic, are subject to other regulations, and benefit from specific types of incentives.

philanthropic actors have long benefited from large volumes of public transfers, tax exemptions, and other State incentives (Nemi, 2020; Ocké-Reis and Santos, 2011; Receita Federal, 2009-2017; Senado Federal, 2018).

The philanthropic sector continued to play a crucial role in access to health care in Brazil following the creation of the universal health system. These establishments had a relatively structured network and widespread presence in the country by the time SUS was created. This was considered as an added value for a system that needed to reach the entire territory and population. At the same time, the philanthropic institutions exerted strong political pressure to maintain their independence and autonomy (Bahia, 2008; Neto, 1997; Senado Federal, 2018). In this way, the government incorporated philanthropic establishments into SUS' chain of provision while maintaining their private nature.

Philanthropic hospitals' participation in SUS is foreseen in the 1988 Constitution and the 1990 Organic Health Laws. This regulation establishes that the universal system "*may resort to services offered by the private sector*" in the cases "*when its available resources are insufficient to guarantee population care coverage in a given area*". It also defines that non-profit entities will have preference over for-profit ones in the cases where the system decides to contract private services (Brazil, 1990a, arts. 24-25).

Philanthropic establishments are in charge of a significant share of SUS service delivery. One can find different values for the share of public provision covered by them, but they converge to about one-third of hospitals providing services for SUS and a similar share in terms of hospital beds.[162] What is even more relevant, these establishments exert a central role in providing complex services and treatments for SUS. Data suggest that, by the late 2010s, they were responsible for almost 60% of SUS high-complexity procedures, 40% of medium-complexity ones, and 7% of outpatient care. Also, about a thousand municipalities in Brazil did not have public health infrastructure, depending on philanthropic entities to access public services (Instituto Filantropia, 2019; Ministério da Saúde, 2018; Senado Federal, 2018).

The philanthropic institutions that work for SUS remain private and autonomous. The federal government reimburses them for the medical goods and services provided on behalf of the system according to the so-called "SUS table", a list of reference prices defined by the Ministry of Health. Besides working for the public system, these institutions can assist private patients, paying and non-paying. They can also provide services to health insurance beneficiaries and run their own health insurance schemes (Pires et al., 2017; Ugá et al., 2008). The relative importance of SUS payments in their total revenue varies. Estimates suggest that around 65% of philanthropic hospitals' revenues come from SUS (Brígida, 2012; CMB, 2013), but this share can reach up to 100% for the many establishments that work exclusively for the public system.

Although it is common practice to refer to the "philanthropic sector" altogether, generalizations must be taken with caution. Under the label of philanthropic entities, there

[162] The remaining share is predominantly public.

are institutions of various sizes and degrees in which they depend on the public system. Philanthropic establishments range from small "Holy Houses" in remote parts of the country to large hospital centers in affluent urban areas. While the former are most often SUS-dependent, the latter also serve private patients and run health insurance plans. Some of the largest philanthropic hospitals in the country have an annual income of several millions of reais, and have even turned to financial markets to raise additional funds (Bahia, 2018; Leis et al., 2003; Nemi, 2020; Sestelo, 2017b; Valor Econômico, 2019). The varied nature of these institutions influences how they will relate to the public sector and their indebtedness process, addressed later in this section.

Philanthropic organizations benefit from massive tax relief and fiscal incentives. According to data compiled by the Brazilian Senate, the federal government spent R$22 billion on philanthropic hospitals in 2017 (Senado Federal, 2018). About 56% of this amount consisted of payments for services rendered to SUS patients, 31% of tax exemptions, 11% of financial incentives, and 2% of monetary transfers in the context of government agreements. Estimates from the Brazilian Revenue Service show that philanthropic organizations working in health-related activities (hospitals and other establishments) profited from a R$6.8 billion federal tax waiver this year (Receita Federal, 2016).[163]

Philanthropic hospitals became increasingly indebted over the past two decades. The reasons for the rising indebtedness levels in the sector are a matter of dispute among the entities' representatives, the government, and researchers in the field. On the one hand, the entities claim that the mismatch between the remuneration received from SUS for services rendered on its behalf and the actual costs of these services is the main cause for the rising debt levels (ALESP, 2015; Câmara dos Deputados, 2016). Government payments for the services provided to SUS would cover about 65% of the actual costs of these services, leading these hospitals to live in permanent deficits (Alves, 2019; Pires et al., 2017). Besides the absence of periodic price adjustments according to the rate of inflation in the health sector, other reasons philanthropic establishments present to explain the increase in debt levels include delays in government transfers, the lack of investments in the health system, and the own logic of public service remuneration based on predefined values for each type of procedure. These establishments claim that this situation brings adverse impacts to SUS by forcing them to implement cost-cutting measures such as staff layoffs, salary cuts, and restrictions on the quality and quantity of services (CMB, 2016).

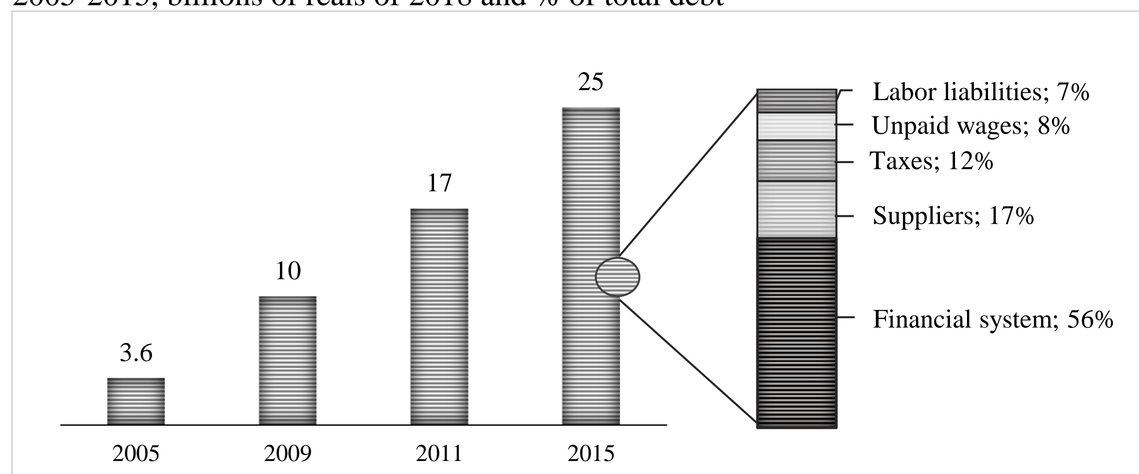
Policymakers, on the other hand, acknowledge issues of underpayment but relativize them in light of evidence of management problems and corruption scandals in philanthropic hospitals, which would contribute to deteriorating their financial accounts (ALESP, 2009; O Globo, 2015). Several scholars also refute the argument that SUS underfunding is the root cause of philanthropic institutions' financial hardship. They contend that working for SUS grants these establishments a continuous flow of patients, revenues, and economic benefits, ensuring their financial sustainability and generating positive externalities for the services they provide outside SUS. They also point out that the sector comprises entities of

[163] Nominal values equivalent to R$23 billion and R$7 billion of 2018, respectively, adjusted for inflation according to the IPCA, or €5.3 billion and €1.6 billion according to the average exchange rate of 2018 (4.3 Reais/Euro).

significantly different sizes, and large hospitals would be able to adjust their strategies to generate income and reap financial benefits from the provision of public services. In particular, these large establishments would use the tax incentives gained from the "philanthropic institution" label to outperform private for-profit competitors (Ocké-Reis, 2018; Fascina, 2009; Lima et al., 2007; Zatta et al., 2003). Considering the sector's heterogeneity, it would be a mistake to generalize its indebtedness process, disregarding that the level and causes of debt are likely to vary across different types of agents (Bahia, 2018; Sestelo, 2017b).

While the reasons for the financial difficulties faced by philanthropic hospitals are a matter of debate, these constraints led them to delay the payments of suppliers, taxes, labor charges, and financial obligations, resulting in a progressive accumulation of debts. This can be seen through the evolution of the total volume of philanthropic hospital debt over the last decade, as well as its structure in the most recent period (Figure 4.7). According to the sector's representative, the total outstanding debt grew from R$3.6 billion in 2005 to R$25 billion in 2015. Breaking down the debt of this latest year, it is possible to observe that more than half of this amount (56%) was owed to the financial system (banks), followed by debts with suppliers (17%), unpaid taxes (12%), delayed salaries (8%), and labor charges (7%). The predominance of the financial sector in the debt structure suggests that these entities were borrowing from banks but were unable to fully honor these obligations – a point that we will develop in the following sections.

Figure 4.7 Brazil, philanthropic health establishments, total sector debt and debt structure, 2005-2015, billions of reais of 2018 and % of total debt



Source: author's elaboration based on CMB (2015). Rounded figures. Constant values of 2018 adjusted for inflation according to the IPCA. Average exchange rate of 2018: 4.3 Reais/Euro

Government programs connecting philanthropic hospitals and banks

Since the late 20th century, the federal government implemented a series of policies to provide financial support to philanthropic hospitals and help them to settle their debts. These policies did not necessarily tackle the causes of the indebtedness problems, which would require, for example, redefining these entities' roles within SUS or increasing the

value of their remuneration for the services provided. Instead, the government opted for alternative strategies to help these entities finance expenditures and refinance debts. These strategies were heavily dependent on financial instruments and institutions.

Government aid to philanthropic hospitals during the 1990s and 2000s came in two main forms. First, the government designed programs for hospitals to refinance their debts with the public sector and suppliers. These programs were based on regulatory shifts allowing hospitals to delay debt repayments, obtain discounts, and enjoy higher tax breaks. Second, the government created special credit lines in public and private banks to make it easier for these establishments to borrow (Bahia, 2008). A review of government measures over the last decade suggests that the first modality had a more prominent place in the State agenda until 2015. It can be considered a "non-financialized" policy orientation in the sense that the measures did not depend directly on the financial sector. For the sake of illustration, one of the largest programs within this category granted philanthropic hospitals the remission of overdue tax debts. It is worth noting, however, that the debts owed to the government, coming from unpaid taxes, constituted a minor share of the philanthropic sector's debt. According to the National Association of Private Hospitals, by the time this program was approved, they represented around one-third of their total outstanding debt (ANAHP, 2013).[164] Unsurprisingly, the incentives granted until the first half of the 2010s were unable to solve the problem, as debts continued to rise.

In the second half of the decade, the federal government started to prioritize the second modality, leaning more toward "financialized" approaches to address philanthropic hospitals' financial difficulties. This was based on policy shifts to both regulate and promote preferential credit lines for philanthropic hospitals in the banking sector. This means, in more simple terms, that hospitals would have privileged access to certain types of loans with more favorable conditions than those they would find as a common borrower. While credit programs were not a novelty in the government agenda, they became the primary focus of State actions to support these institutions in more recent years. We highlight three key measures approved in a row in the period 2015-2018 that reinforced and expanded this policy approach: the regulation of consigned loans guaranteed by SUS revenues (2015), the revitalization of subsidized credit programs to hospitals (2017), and the mobilization of workers' savings to finance these loans (2018).

There is a notable paucity of academic research looking at government policies underpinned by financial instruments and institutions from a critical perspective. Two exceptions are Bahia (2008), who discusses credit lines for philanthropic hospitals more broadly, and Funcia (2021, 2015; and Santos, 2016), who focus on the modality of consigned credit. In the following paragraphs, we will bring together measures that have been analyzed separately in the literature and connect them explicitly with the process of financialization.

[164] The 2013 Program for Strengthening Private Philanthropic Entities and Non-Profit Entities Operating in Health Care (PROSUS). For a list of programs and incentives to philanthropic institutions over the last decades, see Senado Federal (2018).

Consigned credit for philanthropic health establishments

Consigned credit is a popular credit modality in Brazil where loan installments (the monthly repayments on the loan) are automatically discounted from a secure stream of income received by the borrower and addressed directly to the bank. These income streams serve therefore as collateral, making the loan virtually risk-free for the lending institution. In the case of philanthropic hospitals, they can obtain consigned bank credit using SUS revenues to secure the payments.[165] More precisely, these establishments can take out loans whose repayments are discounted from the transfers they receive from the federal government to pay for the medium- and high-complexity services provided in the name of SUS. We will refer to these revenues as "MAC transfers", in which the acronym MAC stands for *média e alta complexidade* (medium and high complexity), a common expression in the national literature.[166]

The federal government, through the National Health Fund, transfers resources to Municipal and State Health Funds to finance medium and high complexity services (whether they have been provided in the public or private sector). In 2018, MAC transfers accounted for 65% of fund-to-fund transfers from the National to subnational Health Funds (FNS, 2020).[167] After receiving these revenues, the State and Municipal Health Funds remit part of these resources to the philanthropic entities that provided such types of services for SUS patients (CGU, 2019; SFC, 2017) (Figure 4.1). Once philanthropic establishments are one of the main providers of medium and high-complexity care for SUS, the largest source of income they receive from the federal government consists of compensations from having provided these services.

Philanthropic hospitals are authorized to take out interest-bearing loans with financial institutions offering as collateral part of their future income from government payments to compensate for the provision of complex services. To put it simply, part of SUS payments to hospitals can service bank loans. Once loan repayments can be discounted from secure income streams received by the borrower, these operations are classified as a form of consigned credit. It is the federal government, through the National Health Fund, which subtracts the corresponding sums from MAC transfers and assigns them to the bank. Some monitoring reports have suggested that the local Health Secretariats, and not the federal

[165] Lavinas (2017) provides a detailed analysis of consigned credit to individuals and how this was the main driver of the expansion of credit to households in Brazil during 2000-2010. In this case, banks offered consigned loans mainly to public servants and retirees. The repayments were automatically discounted from regular income streams guaranteed by the State – in this case, wages and pension benefits. The author considers consigned credit as one of the chief mechanisms allowing the country to enter in the stage of mass-based financialization, incorporating millions of individuals into the financial system through debt.

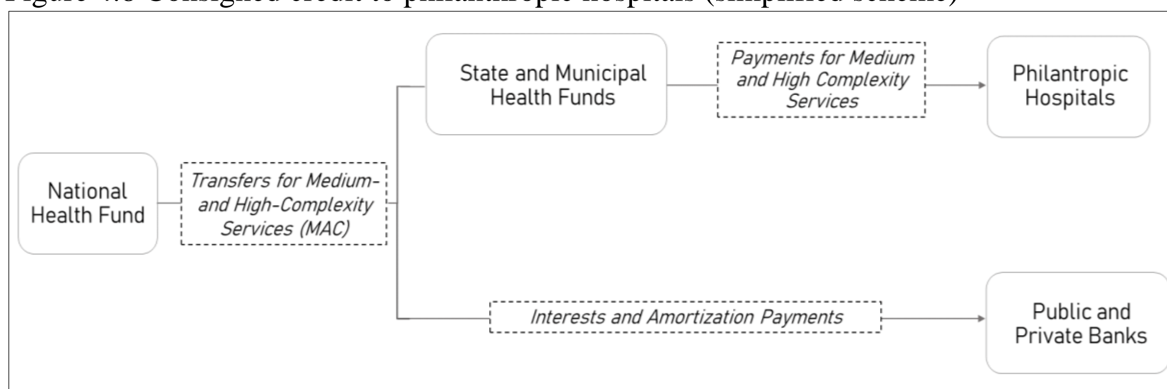
[166] SUS classifies its services according to ascending levels of complexity, defined according to the degree of specialization of the professionals involved, the level of technology required for the procedure, and its costs (Solla and Chioro, 2012). Medium complexity services are those requiring qualified professionals and specialized infrastructure, such as consultations with specialist doctors, out-patient surgeries, and diagnostic imaging tests. High complexity services refer to procedures involving even higher technological content and cost, such as hemodialysis, chemotherapy, and hospital surgeries.

[167] As explained in the previous section, until 2017, nearly the end of the period covered by our research, the federal government organized SUS transfers in six blocks, including for "medium- and high-complexity services". The changes in the model of transfers in 2018 did not alter the use of payments for such services to repay loans.

government, are the ones executing the payments to financial institutions (e.g., SFC, 2014). In any case, it is a public body that executes the repayment. Once government transfers are, as required by law, regular and automatic (see footnote 147), so are the sums deducted from the latter to repay the banks.

The philanthropic hospitals contracted to SUS can engage in multiple contracts with different lenders simultaneously, and may compromise up to 35% of the average revenue from services rendered to SUS in the last 12 months in the form of automatic repayments. These resources cover interests and amortizations. The discounts occur each month for the entire duration of the loan, until it is paid off. Financial institutions are assured to receive the funds automatically as long as the borrower proves it is providing services to SUS (CGU, 2019; Funcia, 2021; SFC, 2017; Silvestre, 2020). In the figure below (Figure 4.8), we offer a simplified view of how the granting of consigned credit to SUS providers works in practice.

Figure 4.8 Consigned credit to philanthropic hospitals (simplified scheme)



Source: author's elaboration based on SFC (2017) and CGU (2019).

It is difficult to determine when exactly philanthropic hospitals started engaging with consigned credit. Banks have been offering special credit facilities to philanthropic hospitals, subsidized by government revenues, at least since the early 1990s (Bahia, 2008). Consigned credit to hospitals seems to have started in 1998, when the Federal Savings Bank (*Caixa Econômica Federal*) created *Caixa Hospitais*, one of the main consigned credit lines to this date. By 2008, more than twenty financial institutions, public and private, were offering consigned credit to philanthropic institutions (ANEPS, 2008). Yet, the first regulation issued by the Ministry of Health mentioning these loans dates from the mid-2010s. Therefore, the practice seems to have grown upon a weakly grounded regulatory framework, based on norms foreign to SUS legislation. During most of this period, the consignment contracts gained legal value through agreements signed by the Ministry of Health directly with the financial institution providing the loan. Meanwhile, public entities mentioned broad legal frameworks to justify the use of this credit modality. One of the few mentions we could find refers to law no. 10,406/2002, the Civil Code, which regulates credit operations more broadly, without any mention of operations in which the borrowers are health care providers (SFC, 2014).

Within SUS' regulatory framework, the first reference to the use of federal transfers

to repay private loans dates from 2015.[168] In an ordinance issued this year, the Ministry of Health mentioned "*the need to regulate the procedures relating to the operation of consigned loans through the cession of credit rights to entities providing services to SUS*" (Brazil, 2015b, preamble). This clearly shows that the practice preceded the regulation. Much like what has been noted in the case of financial investments by Health Funds, we can identify a pattern in which the federal government introduces rules to regulate already existing practices.

More than simply regulating the concession of consigned loans, the 2015 law expanded it by raising the share of revenues that each hospital could commit to debt repayments. While early records mention that the Ministry of Health allowed hospitals to use up to 30% of federal transfers with loan repayments (SFC, 2014), this regularization law increased the so-called "consignable margin" to 35% (art. 3).

The federal government justifies the policy on the grounds that having the repayments guaranteed by the State would allow banks to charge lower interest rates to hospitals, reducing the costs of financing compared to traditional loans (SFC, 2014). The 2015 law, however, does not regulate the interest rates and fees charged by the banks. According to information from the press and philanthropic hospitals' representatives, the interest rates of consigned loans during most of those two decades could reach up to 20-25% per year (ANAHP, 2019; ANEPS, 2008; Instituto Filantropia, 2019; Valor Econômico, 2018).[169]

In 2017, the federal government took a step further in the development of bank-based, publicly sponsored strategies to support philanthropic health establishments by launching another large-scale program for loan subsidization. The *Pro-Santas Casas* program introduced two credit lines for philanthropic hospitals, one for the financing of current expenditures and another for asset restructuring (which includes refinancing and paying off outstanding debts) (Brazil, 2017b). In both cases, the federal government subsidizes the interest rates so they remain below market rates. Any bank can apply to offer these products. The interest rate for working capital loans corresponds to the reference interest rate for long-term loans practiced by the Brazilian Development Bank, set at 7% p.a. in the year the law came into effect. The interest rate for asset restructuring was capped at 0.5% per year. Interest payments and administration fees remain with the lending institution.

The subsidies come from the Ministry of Health's budget, which transfers the resources directly to the banks (Brazil, 2017b, art. 3). The expected cost of the program was R$10 billion – approximately half of what the public sector was spending per year with primary care by the time the program was approved.[170] Using public funds to sponsor loans

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[168] As concluded from searches in the Chamber of Deputies, the Federal Senate, and the Health Ministry's archives (available at www.camara.leg.br, www.senado.leg.br, and www.saude.gov.br/saudelegis). Funcia (2015) reaches a similar conclusion. Within SUS body of norms, the only recent mention in a related topic was ordinance MS no. 220/2007, which authorized State and Municipal Health Secretaries to use revenues from MAC transfers to pay their membership fees to participate in National Health Councils.

[169] See Table 4.6 for the level of basic interest rates and inflation in Brazil during this period.

[170] Public expenditures with basic attention amounted to R$19 billion in 2017, in nominal values (Portal da transparência, 2021). Equivalent to around €2.3 billion according to the average exchange rate of 2018 (4.3 Reais/Euro).

was justified, once again, on the basis that this would allow hospitals to obtain more favorable refinancing conditions compared to what they would be able to get through conventional forms of borrowing (Serra, 2018).

In 2018, the federal government reinforced once again the bank-based approach to hospital financing by mobilizing part of workers' compulsory savings to finance these loans. These refer more precisely to the Length-of-Service Guarantee Fund (*Fundo de Garantia do Tempo de* Serviço – FGTS). The FGTS was created in 1966 as a measure to protect workers from financial hardship upon the termination of their labor contract. It creates a compulsory savings account for each worker during the period of activity, financed by a monthly contribution from the employer proportional to the value of the wage. The account yields a 3% annual return plus monetary restatement, and the worker can withdraw the funds upon dismissal or to finance specific goods and services (namely home purchasing). While workers do not cash in the FGTS benefits, the funds finance government programs related to social and economic development. Since its creation, FGTS contributions have been one of the primary sources of revenue for the federal government to finance public housing programs, sanitation, and infrastructure works (Caixa, 2005).

An official act approved in 2018 determined that part of FGTS funds should be addressed to financial institutions to finance credit operations with philanthropic hospitals. The regulatory shift determines that, each year, 5% of FGTS funds should be transferred to financial institutions to finance philanthropic hospital credit. This was equivalent to R$4 billion when the law was approved (Negrão and Sousa, 2018).[171] The rule maintained the share of FGTS funds allocated to housing investments, thereby sacrificing the amount of funds available for sanitation and infrastructure. Following a period of disputes, the interest rates of FGTS-financed loans were capped at around 12% per year (CMB, 2018).

The bank-based strategy in numbers

Our quantitative analysis will focus on consigned loans, since they existed long before the legislation regulating them and therefore provide us with a more extensive set of data. The National Health Fund discloses information on the volume of federal transfers earmarked to pay for medium- and high- complexity services but reassigned to other purposes. These purposes include covering consigned loan repayments. They also include a number of other expenditures such as refinancing philanthropic hospitals' tax debts, granting funds to university hospitals, and paying for the Health Secretariats' participation fees in National Health councils. The available data do not allow us to separate the amount of discounts from MAC transfers between the share used to repay consigned loans and that allocated to other purposes. However, both the events described so far and the conclusions of official auditing reports (CGU, 2019; SFC, 2017, 2014) give reason to believe that consigned loans absorb most of the funds subtracted from federal transfers for complex services. The Office of the Comptroller General, for example, estimates that deductions from MAC transfers to repay consigned loans alone amounted to R$1.6 billion in 2016 (SFC,

[171] Over €930 million according to the average exchange rate of 2018 (4.3 Reais/Euro).

2017).[172] We find that this represented over half of the deductions registered in the National Health Fund’s database for this year, all purposes combined (FNS, 2020). Moreover, since policies targeting philanthropic hospitals occupied a large space on the government agenda during the last decade, it is reasonable to think that most of the recent increase in the volume of these deductions can be attributed to the higher share of funds granted to the hospitals. Based on the above, we will assess the evolution of deductions for consigned loans using as a proxy the values for total deductions from MAC transfers.

Table 4.13 below displays the values of federal government transfers to states and municipalities destined to finance public health actions and services within SUS, as well as the values deducted from the transfers for complex services and used for other purposes. We can observe that, between 2010 and 2018, R$4.7 billion per year, on average, was subtracted from MAC transfers and used elsewhere. This represented around one-tenth of these transfers. The volume of revenues subtracted from complex services exceeded those spent by the federal government on some core areas of health care provision, such as pharmaceutical assistance (the purchase of medicines and supplies), health surveillance, and investments (namely infrastructure financing). The volume of funds allocated to each one of those categories was nearly half of that deducted from medium- and high-complexity services. The exception was for the year 2018 due to a sudden rise in investment transfers, which is likely to be explained by methodological changes in the way that federal transfers were accounted for in this year.[173]

Table 4.13 Brazil, federal transfers for SUS services and deductions from medium- and high-complexity services (MAC), 2010-2018, billions of reais of 2018

	2010	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*2018*[1]	*Average*
Medium and High Complexity Transfers (MAC)										
Transfers	46.7	48.9	51	49.2	52	50.5	46	48.7	50.9	49.3
Deductions	6.1	5.7	5	4.7	5	4.3	3	4.2	4.1	4.7
Deductions (% Transfers)	*13%*	*12%*	*10%*	*10%*	*10%*	*9%*	*6%*	*9%*	*8%*	*10%*
Other categories										
Primary care	15.5	16.4	19	17.3	18	17.5	17.9	17.9	21.3	17.9
Pharmaceutical Assist.	4.2	3.8	2.8	2.5	2.3	2	2.1	1.8	1.9	2.6
Health Surveillance	2.5	2.5	2.7	3	2.5	2.2	2.9	2.4	2.7	2.6
Investments	0.7	1	1.7	2.4	3	2.5	2.8	1.2	4.4	2.2
SUS Management	0.5	0.3	0.4	0.3	0.1	0.1	0.1	0.1	0.1	0.2

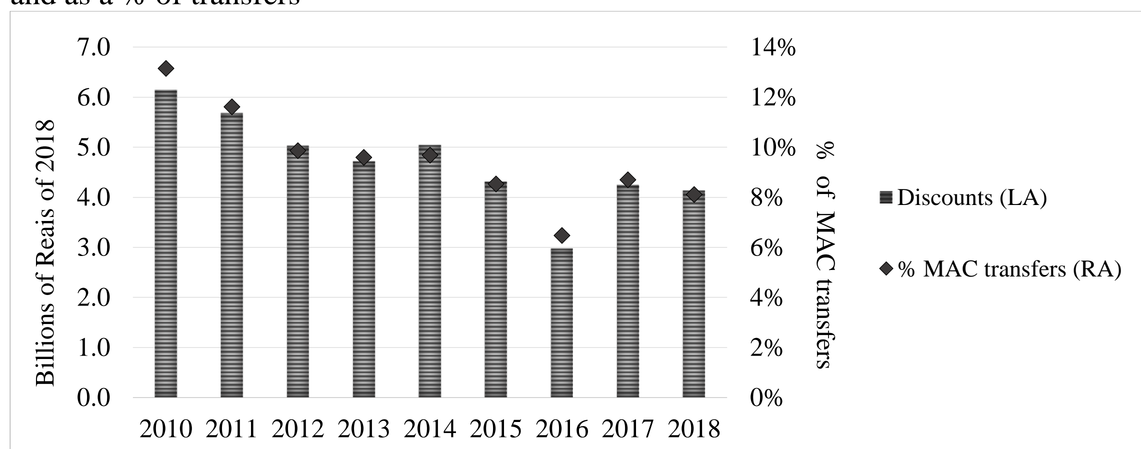
Source: author’s elaboration based on FNS (2020). Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Average exchange rate of 2018: 4.3 Reais/Euro. [1]The method for recording transfers changed in 2018, which explains the surge in investment transfers this year. Due to methodological changes, the series for certain years were adjusted to correspond to the conventional funding blocks (as in 2010, 2011, and 2018).

We can also make a graph out of the figures above to better visualize the evolution of the values deducted from federal transfers to pay for medium- and high-complexity services over time (Figure 4.9). The graph shows this evolution both in constant values of

[172] Values adjusted for inflation according to the IPCA equivalent to R$ 1.5 billion in nominal values and € 1.1 billion using the average exchange rate of 2018 (4.3 Reais/Euro).
[173] See section 4.3.2.

2018 and as a percentage of the federal transfers for these services.

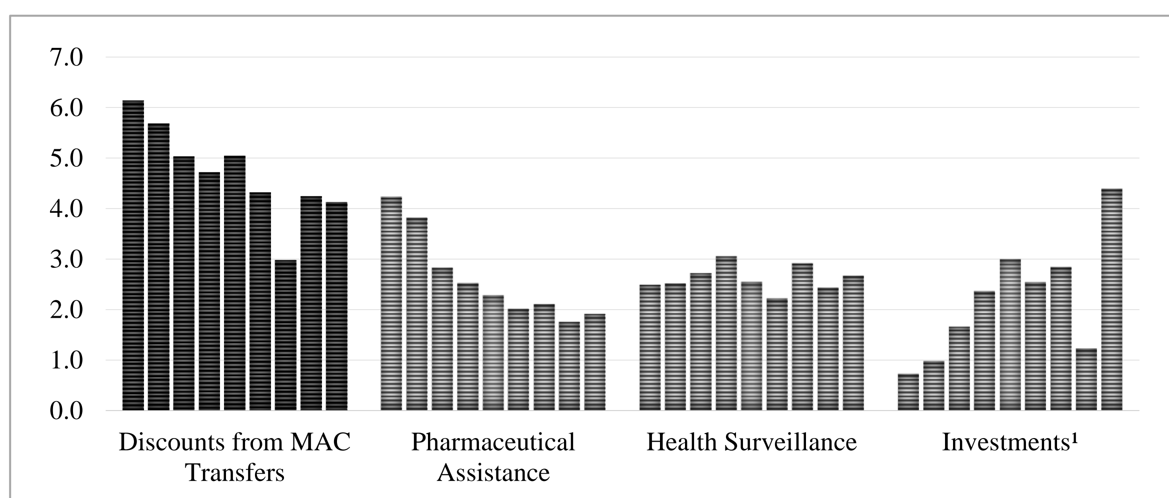
Figure 4.9 Brazil, values deducted from federal transfers for medium- and high-complexity services (MAC) for consigned loans and other items[1], 2010-2018, billions of reais of 2018 and as a % of transfers



Source: author's elaboration based on FNS (2020). [1]Tax debt relief programs for philanthropic hospitals, transfers to university hospitals, fee payments for Health Secretariats, and other forms of compensations and adjustments. Average exchange rate of 2018: 4.3 Reais/Euro. RA: right axis. LA: left axis.

Figure 4.10 compares the value of these discounts with other groups of transfers.

Figure 4.10 Brazil, federal transfers for SUS (selected categories) and values deducted from federal transfers for medium- and high-complexity services (MAC), 2010-2018, billions of reais of 2018



Source: author's elaboration based on FNS (2020). Real values of 2018 adjusted for inflation according to the Consumer Price Index (IPCA). Average exchange rate of 2018: 4.3 Reais/Euro. See SFC (2017) for an earlier version of this graph. The method for accounting transfers changed in 2018, which can explain the rise in the investment series this year.

How credit-based hospital financing serves the financial sector

To conclude our analysis, we can examine the nature of the lenders of consigned loans and how they profit from this strategy. The data we were able to obtain from the

National Health Fund on the institutions providing consigned credit to hospitals is limited to contracts still active by 2019. The records for this year show that both public and private banks benefit from federal transfers. We were able to count nearly a thousand contracts on consigned loans, divided into approximately 65% in public banks and 35% in private ones (FNS, 2019).

The strategies discussed in this section are aligned with the process of financialization to the extent that financial institutions acquire a central role within the PHS and manage to profit from it. First, the system becomes dependent on banks to maintain service delivery. The following statement from the National Health Fund to justify the subsidies on loans illustrates how banks started being seen as critical actors to keep SUS in operation:

> The procedure of consignment through a loan agreement (…) serves the public interest, as it provides these entities with the possibility of anticipating revenues through financial institutions (…) which substantially contribute to keeping their "open doors" and thus assisting the population that seeks quality care in SUS network (FNS, 2014, cited by SFC, 2014).

While sectors of the government and philanthropic entities justify hospital credit as a way to preserve the public provision network, a different reading suggests that these strategies serve the interests of the financial sector. Such strategies are based on the use of public revenues to subsidize and secure loans. As a result, financial institutions not only acquire a central role in the system, but they also end up getting a cut of the funds originally addressed to public health services. This means that subsidized credit programs have undoubtedly contributed to financial accumulation, turning financial institutions into one of the main winners of such strategies.

This is even more so considering that this collateral provided by the government turns the financing of SUS providers into a profitable and virtually risk-free activity for the lenders. Consigned loans are a case in point, once SUS transfers guarantee the regular payment of the installments. Not by chance, financial institutions have referred to philanthropic hospital loans as an important avenue of credit expansion. This modality is promoted on the banks' websites and praised by their representatives (ANEPS, 2008; Funcia, 2021, 2015). As recognized by a manager of one of the first banks to engage with this modality, "*the advantage of this credit [line] is that it has practically zero risk (…) these are perfectly profitable operations for the bank*" (ANEPS, *op. cit.).*

This time again, the capacity of financialized strategies to improve public service delivery can be put into question. Credit programs have the potential to undermine SUS provision, especially when the system's funds are used to pay off debts arising from privately provided services. Investigations from official auditing bodies over the past decade suggest that this might have been the case on several occasions involving consigned loans. Official audit works have found irregularities in these contracts, identifying cases in which SUS transfers were used to repay loans contracted by private hospitals even in the absence of evidence that the money was used to provide services for the public system (CGU, 2019;

SFC, 2017, 2014). As concluded by the federal auditors,

> It is clear that, from the main actors involved in this process – the citizen, the Federal Government, financial institutions, and private SUS service providers taking out loans, only the citizen and the federal government are bearing the risks of the anticipated discounting operation and its consequences. **These are values financed by the citizen and the Treasury that are not converted into public services.** For their part, the financial institutions and the borrowers continue to have their objectives with the discount operations me**t. The latter have already obtained the anticipation of revenues and the former continue, even without ballast for the Treasury, receiving the due monthly installments with their respective accrued interest** (SFC, 2017, p. 14, emphasis added)

This view is supported by Funcia (2015), who examines the evolution of consigned credit to hospitals in Brazil and explains its potential impacts for SUS patients:

> The assignment of credit to pay off the service provider's bank debt (…) is harmful to the interests of the population to the extent that it takes away resources intended for health actions and services, more precisely in the medium- and high-complexity (…) for interest payments to the financial sector.
>
> (…) This constitutes the reallocation of public resources originally destined for the financing of universal health actions and services within SUS to remunerate financial institutions and, thereby, offer new profit opportunities for financial capital, characterizing a redistribution of income in favor of the latter. (pp. 3-4)

Another characteristic of financialized strategies that becomes clear in this case is the diminishing space for transparency and social control in the use of SUS funds. As noted at the beginning of this section, there is no national database on the loans granted to philanthropic health institutions. The official bodies responsible for auditing public accounts report difficulties in monitoring the use of public resources in these operations due to problems in obtaining data (CGU, 2019; SFC, 2017). That SUS funds flow across banks and private health care facilities makes it even more difficult to monitor the practice, as the latter do not disclose information on the loans to the public. This lack of transparency is at least surprising given the large volume of public resources they involve.

Taking stock

Differently from most wealthy countries, the attempts to consolidate the health system in Brazil occurred at a time when financialization was already underway. In this chapter, we have shown how this coincidence of events influenced the structure and trajectory of SUS financing since its early years. Starting in the 1990s, right after its creation, the system was incorporated into financial accumulation strategies and started making use of financial instruments itself.

Our research examined three sets of policies that were particularly important for this process of financialization within the system. The first and most impactful shift came as a

result of the creation of an inflation-targeting regime in the country. To sustain this regime, the federal government implemented fiscal policy measures that directly determined the amount of funds available to SUS each year. This monetary and fiscal policy regime built an arrangement where part of the revenues from the PHS was systematically channeled to pay for interests and amortizations on the public debt, benefitting investors and financial institutions. This included both potential revenues (those that could finance the system had they not been used to cover excessively high charges on the public debt) and effective revenues (those already earmarked to Social Security and reallocated for the same purposes).

We also discussed strategies through which entities in charge of SUS short-term financing and service provision sought to preserve and increase their revenues resorting to financial institutions and instruments. First, we saw that Health Funds, the financial managers of the PHS, were investing the latter's revenues in financial assets seeking monetary returns. More recently, by government decision, these revenues started being automatically invested in financial assets before being invested in service provision.

Second, we also observed that private non-profit providers, an essential link in SUS provision chain, followed a different path, raising funds through debt rather than financial assets. The need to maintain SUS provision served as a justification for authorities to create special credit modalities and use public revenues as collateral for interests and amortizations. The government mobilized several sources of funds to this end, including transfers earmarked for the payment of complex health care treatments and funds from workers' savings. It is interesting to call attention to the connections between such developments and those described in the previous paragraph the constraints to SUS financing due to the heavy burden of financial expenditures on the public debt have been a crucial factor leading other actors involved in the PHS to search for ways to raise additional revenues, which they have found in the financial sector.

Even though the concept of financialization is not made explicit in this passage from Funcia and Santos (2016), the authors seem to agree with our idea that the broader monetary and fiscal policy paradigm in place is connected to the use of financial instruments by actors involved in public health provision:

> **The difficulties in financing public policies, especially in the scope of SUS, is structurally related to the growing commitment of the public debt burden over primary revenues**, by obtaining primary surpluses (…) from 2014 onwards, this situation worsened with the fact that primary revenues were no longer sufficient to fund primary expenses, which has amplified the underfunding process of the SUS (…). **It is in this scenario that the pragmatic and palliative solution of SUS' consigned loans becomes even more attractive** [for philanthropic hospitals] (p. 4, emphasis added).

Summing up, these policies have incorporated SUS into financial accumulation strategies by channeling public health revenues to financial expenditures and allowing the own revenues of the public system to be invested in financial instruments. The State played a central role in bringing about these transformations, as the federal government deliberately

created and enforced new approaches to SUS financing, with other actors involved in the public system following along.

GENERAL CONCLUSION

This study set out to critically examine the ways in which financialization reshapes public health systems (PHS). The originality of this project lied in adopting a new perspective in which these systems are not seen as merely supporting apparatuses for the financialization of health in the private sector. By examining ways in which this process reshapes the financing and provision of public health services, we demonstrated that public systems are also being actively transformed by financialization. In light of these results, we contend that the financialization of health should be seen as a comprehensive phenomenon that encompasses the public and private sectors, with health care serving as a platform for the expansion and accumulation of financial capital in both cases.

The findings of this thesis have significant implications for the understanding of contemporary reforms in PHS. As we have shown, well-established concepts in the field, such as privatization, do not allow us to fully grasp the detailed nature of these transformations in times of financialized capitalism. We used the concept of financialization, a core process of the neoliberal period, to further understand the shifts imposed on these systems over the last decades. Our results show that not only has the financing and provision of public health services been captured in part by the logic of financial accumulation, but that this movement has occurred in both central and peripheral economies. The mechanisms allowing this capture to occur were specific to each case, in line with the different ways in which national systems are structured as well as the country's position in the global balance of power. The increasing participation of financial capital within PHS, along with the growth of private activities in their structures facilitated by this movement, produce a silent yet major revolution in how these systems work. In doing so, they alter the capacity of different sectors of the society to use these systems' resources, with far-reaching consequences for equity and guaranteed access to health care.

To develop our empirical investigation, we conceptualized the financialization of PHS as the increasing participation and influence of financial capital, instruments, interests, and actors in these systems. We then conducted in-depth analyses of the French and the Brazilian PHS from the 1990s to 2018 seeking to apprehend if, and how, this process occurs in practice. The methodological framework we used to guide our investigation is based on the typology of different forms of State financialization first proposed by Karwowski (2019), which we adapted to our research object (see the item "Research design" in the introduction of this thesis). We searched for policies leading the public system to adopt financial logics, engage with financial instruments, and participate in financial accumulation strategies. In line with the original typology that informed our empirical investigation, we use the concept of "financialized policies" in reference to the measures above.

As explained at the beginning of this work, the processes we distinguish here – the adoption of financial logics, the advancement of financial innovations, and the contribution to processes of financial accumulation – are not mutually exclusive. On the contrary, we recognize that they usually go together. Still, this differentiation helps us to better characterize the various types of financialized policies found throughout this work, and in

particular to grasp the differences between processes occurring in central and peripheral countries.

Returning to the hypotheses posed at the beginning of this study, we used this investigation to gain further understanding on: (i) whether and how the process of financialization has been reshaping the ways in which PHS operate; (ii) what is the role of the State in this process; and (iii) to what extent the introduction of financialized policies in these systems can be aligned with principles of equity and solidarity.

The first lesson of this study is that financialization had a major influence on the trajectory traced by these systems since the 1990s. Our findings showed that this influence expressed itself in the increasing incorporation of financial instruments and actors into the financing structures of PHS, leading to a mounting dependence on financial capital for their continued operation and a greater subjection to financial interests in their decision-making processes. The results demonstrate that, contrary to common sense, public systems are not shielded from the advance of financialization. Quite the opposite, it was precisely the magnitude of these systems, universal and comprehensive in nature, which justified the adoption of financialized strategies of similarly large proportions to address financing gaps. The second lesson learned during this investigation was that deliberate State decisions were indispensable in facilitating the marriage of PHS and financial capital. The third lesson was that nor were such shifts neutral, having the capacity to undermine some of the primary roles for which these systems were created.

In the following paragraphs, we summarize our findings with a two-fold goal: on the one hand, unveiling how financialization has expressed itself in each country; on the other, grasping the common logic underlying these seemingly disconnected developments across the world.

Systematizing results: contrasts and common trends

The French system, *Assurance Maladie*, has a unique value to discuss the advance of financialization within PHS. France is historically an international reference when it comes to universal health care and social protection. More recently, the country has become a pioneer in developing complex, financial market-based strategies to tackle challenges in these policy areas.

France has created innovative arrangements that allowed the Social Security system, responsible for financing public health care, to become an active player in financial markets. This was the case for long- and short-term financing, where we showed that Social Security agencies were adopting innovative ways to finance themselves by issuing financial securities. To the best of our knowledge, France is the only country in the world that carried a complex process of financial engineering to transform the Social Security debt into a financial debt held by domestic and foreign investors. Over time, the use of financial instruments spread in the system, serving not only for debt rescheduling and amortization but also to address short-term funding gaps.

We also considered transformations reaching service providers more directly. We also observed a clear inclination toward financialization, this time with the expansion of financial logics to fund physical infrastructure. Public hospitals started to depend on interest-bearing loans from commercial banks to finance investments, a process encouraged by government-sponsored programs. Although loans are not necessarily a financial innovation, the extent to which they have spread throughout the sector represented a novelty in relation to previous forms of financing infrastructure based on interest-free funding.

The table below systematizes our findings for the French case according to our empirical framework.

Systematizing findings 1: France (*Assurance Maladie*)

	Main form of financialization	Policy dimension	Description	Actors involved
Long-term financing (public debt)	Advancing financial innovations	Fiscal policy (revenue side)	Issuance of financial securities to refinance the Social Security debt	Social Debt Amortization Fund (CADES)
Short-term financing (current expenditures)	Advancing financial innovations	Fiscal policy (revenue side)	Issuance of financial securities to finance immediate cash needs	Central Agency of Social Security Organizations (ACOSS)
Hospital financing	Adopting financial logics	Fiscal policy (expenditure side)	Private bank credit to finance infrastructure	Central government and public hospitals

Source: own elaboration. See Figure I for further detail.

The Brazilian experience also provides us with the opportunity to observe in detail how financialization alters the structure of a PHS. While France was a pioneer in developing strategies to adapt its system to the financialization of the world economy, Brazil was one of the only countries in the world that created a universal PHS while this process was already underway. This coincidence of events is a differentiating feature of this case study that allows us to observe how this process can shape a system's trajectory from its very beginning. Brazil is also one of the few peripheral countries that succeeded in creating a comprehensive system of Social Security and a universal health system, thus providing insight into how the peripheral condition can influence the ways in which the financialization of PHS occurs in these cases.

We consider that the most important way in which financialization influenced the trajectory of the Brazilian PHS, *Sistema Único de Saúde*, was by shaping its structures of long-term financing. We observed that the system was incorporated into financial accumulation strategies since its early years as a result of the implementation of an inflation-targeting regime in the country. This monetary policy regime entailed specific measures on the side of fiscal policy that channeled the system's potential and existing revenues to pay interests on the public debt, a move deemed necessary to sustain the macroeconomic order. Brazil is one of the countries that allocates the largest share of public revenues to paying off

public debt interests (financial rents), and possibly the one with the strictest rules on health financing to allow this to happen.

In the case of short-term financing, we observed the incorporation of financial logics by the PHS itself as subnational Health Funds started investing their revenues in short-term financial instruments in an attempt to strengthen their financial soundness. Looking at the financing of providers, a similar incorporation of financial logics was evident in the fact that philanthropic hospitals, a key link on the system's chain of provision, started resorting to interest-bearing loans to finance services. The revenues received from the public system due to services provided on its behalf served as collateral, guaranteeing the automatic repayment of the loans.

The table below systematizes our findings for the case of Brazil.

Systematizing findings 2: Brazil (*Sistema Único de Saúde*)

	Main form of financialization	Policy dimension	Description	Actors involved
Long-term financing (public debt)	Participating in financial accumulation strategies	Monetary policy (inflation targeting)	Budgetary policies appropriating SUS funds to pay for financial expenditures	Federal government
Short-term financing (current expenditures)	Adopting financial logics	Fiscal policy (revenue side)	Use of SUS revenues to carry financial investments	State and Municipal Health Funds
Hospital financing	Adopting financial logics	Fiscal policy (expenditure side)	Private bank credit to hospitals guaranteed by SUS revenues	Federal government and philanthropic hospitals

Source: own elaboration. See Figure I for further detail.

The most important trait shared by these experiences is that they are similarly determined by the global expansion of financial capital in size and power. Although these systems are profoundly different, in both cases we were able to observe instances where material and financial resources from the Social Security and public health systems were transformed into inputs to create or invest in financial instruments, turning financial operations and actors into key elements for these systems to continue operating. In other words, they turned the PHS more dependent on financial instruments, markets, and actors.

Looking at the differences between them, at least two factors seemed relevant to determine how financialization unfolded in each case: one is the system's institutional framework and underlying socioeconomic context; and second is its condition as a central or peripheral economy. France is a wealthy country with solid institutions for the financing of the PHS, presenting relatively high levels of revenue collection and spending. It is also a system based on the social insurance model, where a large part of expenditures consists of reimbursements for services already provided to patients. Both of these factors seem to make service provision have some precedence in importance in relation to financing. In this case, the main challenges for the system's financing were its "deficits" – the lack of revenues to

cover expenditures already incurred by the system. These deficits served as the gateway for financialization mechanisms, which came mainly as strategies to raise additional revenues and refinance debts in the financial markets.

Brazil, in contrast, is a middle-income country whose PHS never reached levels of revenue and spending similar to those of its wealthy counterparts. It is telling that, while core countries with universal systems, such as France, attempt to limit the growth of annual public health spending, part of the financing rules implemented in Brazil during this period sought to force governments to allocate a minimum amount of resources into the system. Also, the Brazilian system is based on the national service model, which means that public health spending is largely discretionary, dependent on government decisions on how much to allocate to service provision. Against this background, it becomes easier to understand why the main challenges to finance the system did not appear in the form of deficits but of underfinancing – the insufficient allocation of resources to carry out all the actions necessary for adequate coverage.

Financialization mechanisms are directly related to underfinancing problems. The most longstanding and important mechanism of financialization, the rules on the federal government and Social Security budget that directly impacted SUS, did not come to provide financing for expenditures already incurred (as in the other case examined in this study). Instead, they prevented public revenues from entering the PHS in the first place, channeling them to the financial sector instead. That this closer relationship between the public health and the financial systems did not result from any form of upfront financing makes the redistributive impacts even more intense in this case, as they undermine the financing of public health services more directly. The peripheral condition seems particularly important to explain these developments. The country's inferior position in the international balance of powers is an important factor in explaining the high levels of interest rates in the country and the influence of external agents in ensuring a monetary and fiscal policy regime that prioritizes servicing the public debt.

The ways in which financialization expressed itself in each case seem to support the ideas laid down by the theory of peripheral financialization (Becker et al., 2010) concerning how this process usually unfolds in central and peripheral economies. According to this theory, the former are more likely to go through a process of financialization pulled by the valorization of assets in financial markets, while the latter will have this process driven by interest-bearing capital (especially in the case of Latin American countries). In our research, we were able to observe that French Social Security bodies began to create their own financial assets and act as financial market participants themselves. In Brazil, by contrast, the dynamics through which the PHS was impacted by the process of financialization had much to do with strategies favoring the accumulation of interest-bearing capital, from both public and private debt.

All this evidence confirms our first hypothesis that financialization transforms PHS, offering an original analysis of the French and Brazilian systems that shows the centrality of this process in their trajectory during the neoliberal period. We can now move on to our two remaining hypotheses, which relate to the role of the State in this process and its impacts on

the capacity of PHS and Social Security systems to fulfill the roles for which they were created.

The reconfiguration of PHS in financialized capitalism and the role of the State

The idea that PHS will tend to disappear due to the advance of financialized capitalism is a misguided interpretation of their transformations in this particular stage. The trajectory of PHS since the 1980s shows that reformulation, rather than extinction, is what best explains their reality in the neoliberal period. Our findings point to a reconfiguration of PHS that is particularly suited for financialized capitalism, adapting to its conditions and favoring its expansion. This is in line with the previous work of Lavinas (2018a), which puts forward the idea of an emerging paradigm of social protection in financialized capitalism. Focusing on the dimension of health care, we provide empirical evidence of what has been described in this latter work for social protection systems more broadly – the transformation of regularities in public systems and its relations with the economy and society as a result of pressures coming from the expansion and accumulation of financial capital.

A particularly important feature that characterizes this reconfiguration of PHS in financialized capitalism, and corroborates the idea of a specific paradigm of social protection in the making, concerns the extension of indebtedness mechanisms. Both in the Social Security more broadly and in the PHS in particular, we observe a tendency to make the systems indebted to the financial sector on a permanent basis. Debt, either with banks or financial market investors, appears as a solution to debt itself. Although many of these mechanisms have been introduced in times of supposed crisis and scarcity of financing, they were never removed once in place. Even in cases where financial engineering allowed the system's debt to decrease in volume, the mechanisms that generate this debt are extended in time and become an integral part of the system. This permanent indebtedness cycle means a greater dependence of the PHS on the financial sector, gradually leading to a situation where the former apparently could no longer work without the latter. While service provision may remain public, the financialization of PHS means that their logic of reproduction is gradually privatized and financialized. In this way, what seems to be a facilitating financing mechanism becomes an instrument of co-optation of the public by the financial sphere.

The findings revealed several occasions where traditional practices and objectives within Social Security have been overshadowed by the advance of typically financialized behaviors. The involvement of Social Security institutions with derivative markets and strategic decision-making on where to issue bonds to maximize financial returns are just a few examples of the emerging financialized logics described throughout this work. The statement of the then Director of ACOSS (the French Central Agency of Social Security) at the National Assembly in 2018 is illustrative of how this market-oriented strategy has reconfigured the traditional *modus operandi* of Social Security:

> Let us be clear: today, ACOSS has no difficulty in placing the debt it manages on the markets, in a context of the search for good public

> signatures and extremely low or even negative rates. It is counterintuitive, I agree, but the debt now brings money to the general regime [of Social Security] (Assemblée Nationale, 2018).

This reconfiguration would be impossible without the State's leadership. The turn of public systems toward financial markets and its incorporation into financial accumulation strategies was not a spontaneous movement, but a product of deliberate government policies in this direction. These policies seem to go in two main directions, reflecting the two key roles taken on by the State in the process of financialization of PHS. These are, one, turning the health system into a platform for the expansion of financial activities and, two, underwriting risks for these activities to succeed.

Starting with the first of these roles, we observe that the State has in many cases passed on to the financial sector the responsibility of managing the problems of the public system. This was done by making regulatory changes so that the financial sector could become the ultimate provider of resources to address the financial shortcomings of PHS. In doing so, it opened up possibilities for financial investments based on public health revenues and activities.

Second, the State acted as an underwriter of these undertakings by providing direct and indirect guarantees to financial investors and institutions. This has usually come with regulations guaranteeing that revenues of the PHS, taxpayer money, or from other public sources would be allocated to cover financial expenditures such as amortizations, interests, and intermediations fees. In France, for example, the State created new contributions and raised existing ones with the explicit goal of repaying the holders of Social Security assets. In addition, there are legal guarantees that the State will assume the responsibility for these obligations in case of solvency problems in the Social Security agencies. In the case of hospitals, government guarantees came through the granting of subsidies for repaying loans. In Brazil, the State enforced a regulatory framework designed to channel fiscal and Social Security resources to interest payments to public debt creditors, prioritizing the use of public resources for financial over health spending. It also ensured secure revenue streams for bodies linked to the PHS to invest in the financial system, in the case of Health Funds, and to borrow from them, in the case of hospitals.

The government, Social Security agencies, and public health bodies justified the introduction of these measures primarily as a way to alleviate public accounts by expanding the sources of income and attracting investments. However, beyond these immediate justifications, we argue that there are far deeper, structural factors leading to these developments. As explained through the notion of the Debt Order proposed by Lemoine (2016), the hierarchization of priorities in the formulation of public policies, with finance at the top, is an important factor in explaining why States live under permanent austerity for the social budget in financialized capitalism. Social spending is seen as a "cost" and the social debt, as a "burden". Policy-making decisions work in line with this view, as is illustrated by the policies discussed in this thesis.

Following this line of reasoning, we argue that the current neoliberal policy

paradigm, and the process of financialization that underpins, have created both the need for PHS to search for financing alternatives, due to a state of permanent austerity in public health spending, and provided the means for these systems to do so, offering opportunities to address financing constraints via financial instruments and strategies. When governments and public agencies attempt to overcome budget shortcomings or imbalances by borrowing from banks, investment funds, and investors, they are trying to cope with these challenges without having to address the structural causes of the financing problems of PHS. Addressing these causes would require measures that are considered off-limits in the current fiscal context, such as changes in the level and structure of taxation. The State's ultimate goal seems less to solve the financial problems of bodies related to public health and Social Security than to boost their capacity to contract and cope with debts, either with banks or financial markets. In this way, it is clear that financialized strategies support the advance of a neoliberal State that requires less taxation and runs on lower levels of public health spending.

The adoption of financial instruments and strategies did not come alone. In line with what was first observed by Chiapello (2017) looking at public policies more broadly, these shifts followed the incorporation of languages, techniques, metrics, organizational structures, and decision-making criteria typical of financial institutions by the public bodies involved in the PHS. This internal reorganization of PHS and Social Security systems has the effects of depoliticizing and artificially naturalizing choices in favor of financial capital, turning them into a seemingly technical decision. This was particularly evident with the creation of agencies and departments specialized in financial operations or the adaptation of existing bodies in a similar direction, which was the case in several instances discussed here. We have shown that both French Social Security agencies and Brazilian Health Funds are largely autonomous in their decision-making processes concerning financial operations, which is often justified in light of the complexity and high levels of financial expertise involved in these operations.

Taken together, our findings suggest that the choices favoring the openness to financial capital have been artificially turned into pragmatic decisions through longstanding efforts to reorganize public priorities at the domestic level, influenced by pressures from the international financial institutions and investors. These decisions are made in a context in which alternatives other than those reliant on financial capital seem hardly feasible. This hybridism – political options, constrained by a broad context that obstructs alternatives – is evident in a statement from CADES' President during an audition in the French Senate, in which he openly recognizes that "*there is the amortization period, the earmarked revenues, and the amount of debt transferred: these are the criteria to be determined, it's mathematical. Then, the choices are political*" (Sénat, 2020, p. 120).

Impacts of financialized policies on the foundational principles of PHS

At first, financialized policies may seem advantageous for public systems by offering them the possibilities of raising additional funds, increasing investments, and reducing financing costs. However, closer scrutiny of these policies reveals that these benefits are

mostly short-lived or have major drawbacks. Notably, they entail different forms of monetary and social costs that are excluded from conventional calculations and introduce new types of risks from which public systems were previously insulated. The potential problems arising from the adoption of financialized strategies can be illustrated by considering their effects on three key pillars of PHS and Social Security systems: promoting solidarity and redistribution among individuals, guaranteeing stable funding for social provision, and ensuring democratic participation in public policy-making processes.

First, bringing these systems closer to financial actors and markets undermine principles of solidarity by allowing the financial sector to appropriate from public funds. Through the policy shifts described here, part of the money transferred (or that should, in principle, be transferred) to the PHS, directly or through the Social Security system, ended up in the hands of financial agents. This came in the form of payments of amortizations, interests, and fees, or conversely to acquire financial assets. The funds for doing so ultimately derived from taxes levied on the population at large. They were addressed to financial investors and institutions, known to be some of the wealthiest individuals and companies in the economy. In this way, such developments weaken the capacity of public systems to promote solidarity and redistribution among individuals.

The costs of these strategies are far from negligible. To mention a few examples, in France, considering only the one of Social Security agency for which there is disaggregated data on interest payments, CADES, we have shown that this has channeled over sixty billion euros to investors and financial institutions in interest payments and commissions from 1996 until 2018, considering real prices of this last year. In 2017, the value of interest paid by this agency was almost the same as would be necessary for the General Regime of Social Security to reach financial equilibrium. In Brazil, we demonstrated that the federal government paid five trillion reais in interest payments to public debt investors from 2000 to 2018 (over one trillion euros, according to the 2018 average exchange rate), while it allocated less than one-third of this amount to health care in the same period.

Another crucial drawback of financialized strategies concerns their detrimental effects on the stability of funding. Financialization trends within social protection and health care systems render the availability of resources determined, in part, by the financing conditions practiced by banks and financial markets. This means subordinating the costs of financing to various factors that are constantly changing and to a great extent beyond the State's control. They include domestic and international interest rates, exchange rates, and inflation rates, and geopolitical events, to mention a few. Moreover, for the financial sector, financing social protection and health activities is an investment like any other, which is only attractive as long as it outperforms alternative investments. These factors can bring sudden changes in the availability and costs of financing for Social Security and PHS. We can conclude that making public systems dependent on the financial sector renders them vulnerable to the latter's inherent and ever more frequent cycles, exposing these systems to unprecedented levels of volatility and risks from which they have been previously distant.

When financing becomes contingent on the "moods" of the markets, the availability and costs of funding are more likely to behave in a pro-cyclical fashion. This undermines

one of the main roles of social protection policies, to make individuals less exposed to the inherent instability of economic cycles. Adding to higher volatility, public bodies are pressed to pursue financial equilibrium at all times to signal to investors the capacity to honor debt obligations, regardless of the economic context. This is also inconsistent with the role of the Social Security system to act as a buffer during economic crises, which requires increases in investments and social benefits in moments of downturn and slowdown in economic activity.

Several practices examined in our investigation revealed that the volume of funds mobilized in the markets, as well as its costs or returns, varied considerably over the years. These variations often accompanied events external to the PHS and Social Security systems. Even if public agencies have been able to reap profits from financial markets operations in some cases, this increased dependency on the latter made the financing of public health care more, not less exposed to the reversal of current conditions. For example, although French Social Security agencies have earned income by borrowing at negative interest rates since the mid-2010s, the institutions themselves recognize the role of the meager international interest rates in this period in contributing to these results and their greater exposure to interest rate risks, whose increase could bring a sudden reversal of financing conditions (Assemblée Nationale, 2016; IGAS, 2018). In the case of Brazil, the level of interest rates determined the volume of revenues spent on the public debt, which in turn dictated what would be available to other areas, including the PHS.

A final issue associated with the greater dependency on financial capital concerns the erosion of these systems' capacity to serve as an instrument of democratic participation. To the extent that public systems become dependent on investors, banks, and rating agencies to operate, their decision-making processes are increasingly subjected to the interests and requirements of these actors. These usually go in the direction of requiring public systems to exhibit positive financial results and demonstrate their ability to meet debt repayments. Such priorities can go against the interests and needs of the population, as they are likely to constrain the volume of revenues spent with social provision.

During our research, we observed several instances where the use of financial instruments allowed public entities to incorporate an "investor mentality" previously foreign to them and pursue the maximization of monetary returns against other goals. It is telling, for example, that French Social Security agencies have gambled with interest rate differentials to reap income in international financial markets, and that Brazilian Health Funds have withheld money from the PHS in the financial system to improve their accounts. This suggests a fundamental opposition between the interests of financial actors, focused on maximizing monetary gains and maintaining positive financial results, and the collectivity, based on redistributing resources and investing in public provision. This reversal of positions in decision-making criteria, with finance over users, along with the channeling of income to the former, suggests that PHS are undergoing a process of capture at both the ideological and material levels.

Despite compelling evidence that financing social provision through financial capital alters the balance of powers in favor of financial actors, it is virtually impossible to

determine to what extent this can affect the quantity and quality of services rendered to the population. The proper assessment of the financial and social costs of these strategies is seriously compromised by transparency problems. Public databases fail to provide uniform, up-to-date, easily workable data on the institutions and instruments in which the resources were invested, the volume of returns, and the length of investments, to cite a few. In this way, the available information is often insufficient to conduct adequate evaluations. The complexity and opacity of the financial system play a major role in explaining these challenges. When using financial instruments, the origins of the funds to finance Social Security and the PHS (as well as the destination of the reimbursements later on) cannot be fully known due to confidentiality agreements and the multi-layered, dispersed organization of financial markets. Lack of transparency is, thus, a critical problem that undermines civil society's ability to weigh in and decide on the policies undertaken by Social Security and PHS.

Taken together, the drawbacks described so far disprove common arguments used in favor of pro-market reforms, including the assumptions that all losses can be measured, compensated for, and benefit the society in the long run (Arestis et al., 2015). They reveal that the shifts brought about by financialized policies are to a large extent inconsistent with the fundamental principles of public systems, which represent their very *raison d'être*. The mounting challenges and deteriorating state of several aspects of PHS provision in the last decades reinforce the argument that financial investors and institutions have benefitted more than citizens from current reforms.

Looking at ongoing transformations in PHS through the lens of financialization is, therefore, a valuable task, allowing us to uncover who may be pushing for present-day reforms, how they come about, and what problems they may pose for universal, solidarity-based systems. In 2016, the president of CADES himself acknowledged the conflicts of interests inherent to these shifts, stating before the National Assembly: "*when CADES was created, I was working as an insurer. At the time, I prohibited the purchase of CADES' securities, considering that Social Security should not be financed in such a way*" (Assemblée Nationale, 2016, p. 15).

These results are also important in that they show that it is no longer sufficient to fight for public systems. In times of financialized capitalism, it is also necessary to strive for systems that do not depend directly on financial capital to function. To contemplate alternatives, one must question the reasons leading public systems to face such a need for additional funding in the first place. These challenges are strongly related to the fact that Social Security and PHS revenues have not increased sufficiently to keep pace with their expenditures over the past decades. Such a mismatch is inextricably linked to the resistance of neoliberal governments to tax private capital in general and finance in particular, the latter a major *locus* of income and wealth concentration in times of financialized capitalism. In this context, it is no surprise that the continued accumulation of capital in the hands of

financial players compromises the volume of resources available to finance public services.

Avenues for future research

In light of the fact that austerity policies, market-friendly government agendas, and the growing power of financial actors are common trends in several countries, the financialization of PHS represents a crucial avenue of investigation. The limitations of our work in time and space, as it is focused on two countries for the pre-COVID period, represent perspectives for further research. Although this study has successfully demonstrated the influence of financialization in reshaping the financing of PHS, further research is needed to apprehend how this process unfolds in other countries. The analytical framework suggested in this work can be applied to other case studies, contributing to understanding how financialization takes place across different national settings.

Future research could also seek to apprehend the effects of the coronavirus pandemic starting in 2020 on the creation and deepening of links between PHS and financial capital. This watershed event represented one of the largest shocks that PHS have ever faced, demanding unprecedented levels of material and financial resources to deal with the sanitary crisis. Our empirical research, limited to 2018, was unable to capture the impacts of these recent events on the financing strategies of PHS. It would be important to investigate not only the impact of the pandemic on the accounts of health and Social Security systems, but also how financialization may have shaped the ways in which they responded to these pressures.

Our study focused on the dimension of financing, looking at changes in the management of current expenditures, deficits, and debts. Another possible area of future research would be therefore to investigate in greater detail developments in other dimensions, notably in terms of how financialization reshapes more directly the realm of public provision. Further research might explore the indirect entrance of financial capital into PHS through private providers working for the public system or insurance funds associated with it. As pointed out in our review of the available research, there is reason to think that the latter are becoming increasingly integrated into financial structures and acting as financial agents themselves (see Bayliss, 2016). A particularly promising area for further work concerns the case of PPPs, a special type of venture that conjugates aspects of financing and provision. Although there are PPP projects to build and operate public hospitals in both France and Brazil, the resort to these strategies is still limited compared to some other countries with PHS, such as England or Canada. Still, there is reason to think that these proposals are gaining traction over time, making the study of PPPs an important element in this research agenda.

To conclude, another valuable research topic would be to assess the costs of these strategies seeking to incorporate social, political, and economic impacts. The findings of this study revealed that these are often excluded from standard calculations, which pose serious accountability problems to PHS.

This permanent indebtedness cycle means a greater dependence of the PHS on the financial sector, gradually leading to a situation where the former apparently could no longer work without the latter. While service provision may remain public, the financialization of PHS means that their logic of reproduction is gradually privatized and financialized. In this way, what seems to be a facilitating financing mechanism becomes an instrument of co-optation of the public by the financial sphere.

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ANNEX 1. TABLE: PRIVATIZATION AND FINANCIALIZATION IN THE HEALTH SECTOR

Privatization and Financialization in the Health Sector: Systematizing Prominent Features[1]

	Privatization	Financialization
Key period	1980s-1990s	2000s-2010s
Common aspects covered in definitions	– The adoption of a corporate rationale (e.g., languages, metrics, goals of nonfinancial private companies) by public bodies – The incorporation of practices and actors from the private health sector into public structures of management, financing, and provision	– The adoption of a financial rationale (e.g., languages, metrics, goals of financial companies) by public bodies – The incorporation of practices and actors from the private financial sector into public structures of financing, management, and provision
Examples of policy shifts	– Introduction of private practice in public establishments – Outsourcing of public services to private providers – Cost-shifting onto patients and insurers (e.g., introduction or rise of co-payments)	– Public-Private Partnerships Social Impact Bonds – Issuance of securities – Contracting of debt – Undertaking of financial investments
Main private actors concerned	– Private providers of health goods, services, and insurance (“private non-financial sector”)[2] Examples: for- and not-for-profit hospitals, clinics, laboratories, health insurance funds	– Private providers of funds and investments (“private financial sector”) – Examples: for- and not-for-profit banks, investment funds, financial investors, multinational non-specialized insurance companies
Main features of private actors concerned: health companies	– Family or individual ownership, often owned by health professionals. – Weaker connections with financial institutions and investors. Lower levels of leveraging. – Specialized in health activities (producing and trading health goods and services) – Goal of generating operating profits – Expansion led by the incremental consumption of drugs, services, and equipment	– Corporate ownership, often owned, controlled, or highly leveraged by financial companies and investors. – Previous owners (individuals or family representatives) can be integrated into the newly formed structures – Not specialized in health activities (companies with a diverse investment portfolio) – Increasing goal of generating financial income (e.g. interest payments, dividends, capital gains, fees)

(continue)

Main features of private actors concerned: insurance companies[2]	– Smaller companies, lower levels of concentration in the sector – Often dissociated from other financial institutions – Important non-profit segment, benefits based on solidarity principles	– Larger companies, higher levels – of concentration in the sector – Increasingly associated with larger financial institutions – Expanding for-profit segment, with benefits defined according to the value of contributions – In both cases (health and insurance companies), Expansion led by investment strategies (e.g. mergers and acquisitions, internationalization, private equity investments)
Narrative and arguments pro-reforms	– Public sector portrayed as overspending and inefficient – Public actors are inherently prone to corruption and inefficiency. Profit motive, competition, and ownership rights can render superior outcomes. – Privatization reforms would reduce public costs and promote efficiency gains.	– Public sector portrayed as financially strapped – The financial sector can price and allocate resources efficiently. In particular, it can raise a higher amount of funds at lower costs than the public sector. – Financialization reforms would bring revenues into the public system and reduce the costs of financing.
Underlying process	“Commodification”: assigning properties of a commodity to something previously not treated as such. In health, commodification can be seen when activities for health financing and provision are given a monetary value and start being negotiated according to the market logic, with different agents buying and selling health goods and services.	“Assetization”: assigning properties of a financial asset to something previously not treated as such. In health, assetization can be seen when activities for health financing and provision are assessed based on risks and returns and transformed into investment opportunities, representing a claim on ownership or contractual rights to future payments.

(continue)

Theoretical underpinnings	– Assumptions from different theories grounded on neoclassical Economics (e.g., theory of property rights, theory of the firm, theory of public choice). – More explicit attempt to anchor the case for privatization in theoretical arguments.	– Assumptions from finance theories grounded on neoclassical Economics (e.g., "efficient market hypothesis") – Hardly any explicit reference to finance theories to make the case for financialization; measures presented as pragmatic solutions rather than theoretically-informed policy shifts.
Adverse impacts according to critical studies	– Deterioration in the quality and quantity of public provision – Deterioration of employment conditions – Increase in private health spending – Increase in inequalities of access to health services from the downsizing of public provision and the externalization of costs	– Intensification of impacts associated with privatization – Loss of transparency and accountability – Heightened volatility of public financing – Increase in income concentration from the use of public funds to pay for financial returns
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Sources: author's elaboration based on the references listed above. Notes: [1]This differentiation does not mean that privatization and financialization are seen as exclusionary processes: privatization processes occur up to today, and developments associated with financialization started to emerge before the 2000s. The columns attempt to contrast the features of actors and processes leading transformations in the sector in each period. [2]Although insurance companies are formally classified as financial actors, the private health insurance companies from the past had significant different features compared to the financial companies taking over the health sector today; therefore, for the sake of simplification, we consider the former together with health companies. [3]The references were classified according to the core concept of the study; however, there is an overlap in references, meaning that in some cases they contributed to characterize both phases.

ANNEX 2. ADDITIONAL INFORMATION ON DATA SOURCES AND TREATMENT

Except when stated otherwise, the data presented in this work were collected and systematized by us from available documents disclosed by public institutions. We prioritized annual reports and financial statements from Social Security and public health agencies, statistical agencies, and supervisory auditing bodies.

The primary sources of information to examine the French case were: (i) annual reports and financial statements from Social Security agencies (ACOSS and CADES), (ii) statistics from the Health and Solidarity Ministerial Statistical Department's database (DREES), (iii) selected reports from the French Supreme Audit Institution (Cour des Comptes), and (iv) documents registered at the national regulatory agency of financial markets (AMF). These data are relatively well systematized, and all the adjustments made to them have been already described in the Introduction (section "data sources and adjustments").

In the case of Brazil, we combined information from: (i) publicly available databases from official public bodies, including the Health Ministry, the Brazilian National Treasury, the Central Bank, and the Federal Revenue Service, (ii) financial statements provided by state Health secretariats in response to our requests through the Law of Access to Information, and (iii) reports from public audit institutions, such as SUS Audit Department and the Public Prosecutor's Office. The information obtained through the Law of Access to Information remains available for consultation with the entities that have responded to the requests. They can be accessed using the following protocol numbers: SICSP 424771913690 and 49696192553 for São Paulo, e-SIC 3772 for Rio de Janeiro, and e-SIC 00060000407201941 for the Federal District. In the cases where the quality or quantity of available data were unsatisfactory, we complemented the analysis with information retrieved in academic papers and articles from the press.

There are greater challenges in terms of data collection and treatment in Brazil, warranting further explanation of the figures used for this country. In the case of State Health Funds (section 4.3.2), we found diverging information on the financial investments carried by the Rio de Janeiro Fund State Health Fund across a number of public databases, such as the state's "Fiscal Transparency Portal" (*Portal Transparência Fiscal do Estado do Rio de Janeiro*), "General Accounting Portal" (*Portal de Contabilidade Geral do Estado do Rio de Janeiro*), and the Treasury Secretariat's website (*Secretaria de Estado de Fazenda*). These sources followed different reporting methods and presented conflicting values for investments in financial instruments by the state Health Fund. In the case of the Federal District, we could not find information for financial investments in public data repositories with information for the Health Fund, including in the websites of the Federal District Health Secretariat (*Secretaria de Saúde do Distrito Federal*) and the Federal District Court of Accounts (*Tribunal de Contas do Distrito Federal*). Therefore, we could not build homogeneous, long-term data series based on these sources. We sought to overcome these

challenges by submitting information requests to the State Health Secretariats of both Rio de Janeiro and the Federal District under the Federal Law of Access to Information. We use the data on financial investments provided in response to these requests to build the series examined in this study. We consider this to be the most reliable source of available information to the extent that the Secretariats are the agencies that control the Health Funds and, therefore, can provide the most detailed and up-to-date information on these investments. Our initial research scope also included the São Paulo State Health Fund, as São Paulo is the richest and most populous state in the country. However, this was excluded from the final discussion as the data provided by the public administration in this case were insufficiently detailed for an adequate analysis.

In the case of philanthropic hospitals (section 4.3.3), we examined the case of consigned hospital loans using based on the volume of revenues from the National Health Fund used to repay consigned loans. The values used as a proxy were the volume of revenues from the National Health Fund channeled to all purposes other than paying for high and medium-complexity services, which include consigned loans. Using values for total deductions, including loans but also other items, is justified in light of the absence of a series for loan repayments alone. We requested this information from the National Health Fund through the Law of Access to Information, but the entity was unable to provide a consolidated series for this item alleging the lack of operational tools to do so. The protocol numbers for the information requests are e-sic n. 25820006773201995 and n. 25820003194202024. The National Health Fund's information system only allows extracting values for revenues destined to loan installments for one health establishment at a time, rendering it infeasible to build a long-term dataset on the total volume of SUS transfers for such purposes at the national level. Although the institution recommended searching the archives on its website, we were unable to find this information in the places it indicated. Considering solid evidence that the largest share of the revenues subtracted from the National Health Fund's transfers to subnational Funds is due to loan repayments, we consider the former as a valid proxy to examine the latter's evolution over time.