

BANKING ON HEALTH: *the surging pandemic of health financialization*



*Economic and social development,
based on a New International Economic Order,
is of basic importance
to the fullest attainment of health for all
and to the reduction of the gap
between the health status of the
developing and developed countries.*

ALMA ATA DECLARATION, WHO, SEPTEMBER 1978



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EXECUTIVE SUMMARY

In the last three decades, **health financialization has surged in several creative ways**, yet this growing phenomenon remains surprisingly unknown, and neglected, in the global health arena. Financialization in the health domain could be described as the uncontrolled expansion of finance along various lines of healthcare provision. Health has been intentionally transformed into a commodity as private for-profit actors have been allowed freedom to operate - and ultimately play with people's fundamental right to health - for their vested financial interests, nationally and internationally. Health financialization is thrivingly pursued today for example through the institutionalization of medical knowledge monopolies, the expansion of markets and of financial techniques applied to healthcare insurance schemes, the soaring digitalization of global health interventions and the booming data industry.

Even the capitalization of development aid has become a key driver of health financialization. After the unprecedented financial crisis in 2008, bringing private sector investment to the center of development policies gained new traction, a smart excuse for rich countries to decline their overseas development assistance (ODA) funding, and (more importantly) a chance for them to internationalize support to their own domestic firms and investors. In the health sector this trend has resulted in a contractual governance landscape in which health strategies, distributive schemes, practical ethics of healthcare and decision-making prerogatives have been constantly outsourced to private entities.

Public and private partnerships (PPPs) have been instrumental to enhancing health financialization, and it is difficult to underestimate the governance hazards that come with the institutional hybridization embedded in most PPPs, particularly when private-law regimes and market-based approaches are supposed to be delivering health public goods. Evidence gathered by researchers in the health field reveals a reality that - in rich and low-income countries alike - challenges the dogmas of the fettered PPP model, while measuring PPPs' misrepresentation and broken promises. This evidence is compounded by recent findings of the first ever WHO

report on Public-Private Partnerships for healthcare infrastructure and services. Examining evidence of PPPs in the middle-income countries in the European region, the WHO welcome diagnosis also seems to convey a rather problematic sense of reality, when it comes to PPPs in healthcare.

The management of COVID-19 has been a textbook manifestation of the negative externalities associated to health financialization trends on a global scale. The pandemic has illustrated multiple and catastrophic instances of market failure in private health services globally, with serious implications for the pandemic response. However, the unprecedented health emergency has not generated any retreat from private health and from the partnership model that has defined engagement with the financial private sector for global health interventions - as is the case of the International Financial Facility for Immunization (IFFIm) - in the last decades. Neoliberal policies remain too deeply entrenched in the multilateral development institutions that arbitrate global health policy for them to even conceive reorienting the private first approach towards more equal and sustainable financial policies. Instead of changing course, they appear to double down on neoliberal commitments, as witnessed with the inequity of pandemic proportions in the distribution of vaccines enshrined in the COVAX scheme. In fact, with the blessing of the international community, a new architecture driven by a recently-bred hierarchy of digital solutions is moving health securitization forward through the logic of immunity as the new organizing principle. A disquieting scenario that threatens the very legitimacy of the public function.

1 - HEALTH FOR ALL, REALLY?

The intrinsic correlation between the quality of the international economic order and the realization of the right to health, pioneered in the Alma Ata Declaration¹, has unequivocally manifested itself during the past three years of the Covid-19 pandemic. Only a few years after the mobilizing pronouncements of the Alma Ata conference in 1978, setting Health for All as the primary horizon for enabling human and economic development, financial institutions and the infrastructures of financial intermediation started to gradually become key drivers of the world's economic dis-order². This trend deeply challenged the Alma-Ata sense of direction. Finance started to make money from money by shaping markets for the buying and selling of credits and debts. Financial players have gained unprecedented influence over our lives, subjugating health goals to shareholder values, market fluctuations and failures. After the pandemic, the discourse about the economics of Health for All has gained new meanings, and a new sense of urgency³. But in the meantime, health has been transfigured, and the moral economy of health interventions along with it.

Health financialization has grown in complex and creative ways, still emerging through the creation of new asset classes for private investments and bonds, the institutionalization of medical knowledge monopolies, the expansion of markets and financial techniques applied to healthcare insurance schemes, and the capitalization of development aid. The intentional involvement of the private for-profit sector in healthcare, often under the travesties of modernized overseas development assistance (ODA)⁴, makes it difficult to draw a clear line between health financialization's specific profit motives and the contiguous interfacing spheres of health privatization and health financing. Intersections are stratified in a rising contractual governance landscape engaged to tackle global health needs, in which health strategies, distributive schemes, practical ethics of healthcare and decision-making prerogatives are progressively being outsourced to private entities. As we have witnessed during Covid-19 through the failed international allocation of vaccines to counter the contagion⁵, this expanding policy inclination is unfit to offer legitimate solutions to the tension between the profit maximization imperatives of private finance and the long-term investments that are essential to advance Health for All⁶.

1 <https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata>

2 Dutta, S.J., (2018). *Financialization: a primer*. Transnational Institute, October 2018, Amsterdam, <https://www.tni.org/en/publication/financialisation-a-primer>

3 <https://www.who.int/publications/m/item/council-brief-no-2>

4 <https://www.oecd.org/dac/financing-sustainable-development>

5 <https://stopaids.org.uk/resources/access-denied-what-happens-when-big-pharma-is-in-the-drivers-seat/>

6 Banco, E., Furlong, A., Pfahler, L., (2022). How Bill Gates and partners used their clout to control the global

Whereas a healthy and sustainable environment inhabited by a healthy population should be the ultimate purpose of economic activity, health continues to be viewed as a variable in the economic equation, a marginal arena of economic policies, dissociated from the contribution it provides to enhancing the social fabric of a thriving society. Even after COVID-19, the perception firmly remains that health is a cost that governments may outsource and hand over to private financial players in exchange for new profit-making possibilities. The process of making health rights dependent on financial markets was much prodded in pandemic years by the need to contain the SARS-CoV-2 coronavirus, and the expansion of digital technologies. As happens in other sectors, the expansion of financial markets for health is not only about the volumes of financial trading, but also the mounting diversity of transactions and market actors in their intersection with all segments of economy and society. The phenomenon, touted under the banner of the 2030 Agenda and the provision of Universal Health Coverage (UHC), presents a range of critical implications in terms of health governance and policy priorities, corporate sector monopolies, the cultural and political redefinition of the way the universal right to health should be interpreted and pursued, in a context of sharp decline in democratic accountability.

2 - FINANCIALIZATION: WHY IT MATTERS FOR HEALTH

The model of our economic development, and the fabric of our lives within it, are profoundly determined and affected by financial flows and their volatility. This reality, commonly described as *financialization*, refers to “the increasing role of financial motives, financial markets, financial actors and financial institutions in the operations of domestic and international economies” according to the most cited definition⁷. Through privatization, deregulation, and credit flows, financialization has overseen a large-scale conversion of public wealth into private capitals. This route has allowed financial actors such as asset managers, commercial banks and insurance companies to gain greater influence in global economic governance, including through an array of highly influential pervasive strategies within the multilateral system, with significant implications for the development agenda.

Such a radical transformation has significantly reshaped economies and societies, syphoning wealth from the “real economy”⁸, mounting pressures on indebted households,

Covid response – with little oversight. In *Politico and Welt*, 14th September 2022, <https://www.politico.com/news/2022/09/14/global-covid-pandemic-response-bill-gates-partners-00053969>

7 Epstein, G.A., (2006). “Introduction: Financialization and the World Economy”, in Epstein, G.A, ed., *Financialization and the World Economy*. Cheltenham: Edward Elgar Publishing Ltd., 2006, pp. 3-16. <https://peri.umass.edu/fileadmin/pdf/programs/globalization/financialization/chapter1.pdf>

8 <https://unctad.org/tldr2022>

sharpening inequalities between the economically privileged and the swelling world of precarity in which people live today. When talking about healthcare, this scenario has paved the way to the Golden Age of a solid medical-industrial complex steered by what could be defined the *magic bullet* approach, namely the delivery of health technologies (novel medicines or devices) that target one specific disease, without the least consideration of the social, economic, or political determinants that induce it and impact outcome. The biomedical paradigm has taken over as the norm in global health interventions, increasingly combined with a thriving medical insurance industry that has asserted its dominance as a most sophisticated trope of capital formation of previously non-commodified assets⁹.

The breakthrough event of the 2008 financial crisis has exposed these trends to global judgement, when major banks were bailed out by taxpayers' money to cover the risks taken by private financiers, while states completely lost sight of their constitutional obligations and resorted to wild austerity measures¹⁰. EU policies for example produced a ferocious deterioration of Greek population's overall health status in the years of loan agreements and austerity cuts that followed the 2008 financial shock, as impeccably documented by the National Bank of Greece in 2016¹¹. In fact, the impact of the crisis has affected people's lives with a disturbing legacy in the following years, well beyond the Greek boundaries¹². Economic and social policies that have focused excessively on fiscal discipline, despite the increase in care needs, are at the origin of many years of healthcare systems' weakness, a condition that has provoked acute challenges when COVID-19 *tsunamied* European countries¹³. The outbreak of COVID-19 has glaringly exposed the repercussions of cuts on public expenditures that have hollowed out and privatized public services in health, stifled social protection¹⁴, and resulted in a failed response to the pandemic, not only in Europe¹⁵.

Laissez-faire strategies clearly did not work then, but they have not been abandoned. Trillions of dollars went to repairing the financial system but hardly with any serious reform, paradoxically allowing many of the practices that had generated the crisis to settle back in. Following the 2008 storm, new cycles of financial instability have been ushered. The conventional notion that increasing the quantity of money through strategies

9 Hunter, B.M., Murray S.F., (2019). Deconstructing the Financialization of Healthcare. In *Development and Change*, Volume 50, issue 5, pp. 1263-1287, <https://onlinelibrary.wiley.com/doi/full/10.1111/dech.12517>

10 Ortiz, I., Cummins, M., (2013). "The age of austerity: a review of public expenditures and adjustment measures in 181 countries", Working Paper, Initiative for Policy Dialogue and South Centre, 24th March 2013, New York, and Geneva. https://policydialogue.org/files/publications/Age_of_Austerity_Ortiz_and_Cummins.pdf

11 <https://greekreporter.com/2016/06/17/bank-of-greece-report-concludes-greeks-health-deteriorating-life-expectancy-shrinks>

12 Ortiz, I., Cummins, M. (2019). "The Insanity of Austerity". In *Project Syndicate*, 11th October 2019, <https://www.project-syndicate.org/onpoint/the-insanity-of-austerity-by-isabel-ortiz-and-matthew-cummins-2019-10>

13 <https://www.etuc.org/en/document/covid19-impact-health-care-cuts>

14 <https://g2h2.org/wp-content/uploads/2022/11/G2H2-Report-2022.pdf>, pp. 13-24.

15 <https://theindependentpanel.org>

of quantitative easing (QE) would boost wealth trickling through the real economy has proven overestimated - to say the least - leading to a renewed increase of cash hoarding, with the money simply fueling asset speculations in the financial system again, instead of being used on production¹⁶. After 2008, however, bringing private sector investment to the center of development policies gained new traction, a smart excuse for rich countries to decline their overseas development assistance (ODA) funding and, more importantly, a chance for them to internationalize their support to their own domestic firms and investors¹⁷. The paradox is indeed only apparent. That is instead the price to be paid for maintaining the agonistic relationship among people, markets and institutions, in a global capital order which thrives *in* and *through* crises¹⁸.

3 - 30 YEARS OF HEALTH FINANCIALIZATION

The stimulus to private financial capital into the healthcare sector dates to the historic World Bank's 1993 report *Investing in Health* and its analysis on the interplay between human health, health policies and economic development¹⁹. The main question addressed was what the public sector should do in health. The report introduced new criteria for priority setting in public health spending through the lens of "cost-effective" interventions and the definition of "essential package of care" varying according to the countries' disease burden and their willingness/ability to invest in health, with a minimum set of services to be provided for US\$ 12 to US\$ 22 per person/year. Public resources used in that way would maximize value for money and concentrate benefits on the poor.

The report produced a robust impact on health policies, introducing a range of reforms that have weighed an ever-increasing importance on generating markets and cash income through the commodification of healthcare. Governments had to promote competitive provision and efficiency in the use of both public and private resources²⁰. The reform's implementation was devised through widespread moratoria on the expansion of healthcare provision in countries, the contracting of ancillary services in hospitals, and the introduction of highly contentious users' fees schemes for health services²¹ as an effective means of generating revenue and enabling health service quality improvement

16 Skidelsky, R., (2021). Where Has All the Money Gone? In *Project Syndicate*, 15th September 2021, <https://www.project-syndicate.org/commentary/quantitative-easing-has-fueled-financial-instability-by-robert-skidelsky-2021-09>

17 <https://www.eurodad.org/a-dangerous-blend>

18 Klein, N., (2008). *The Shock Doctrine. The Rise of Disaster Capitalism*. Penguin Books, 2008.

19 <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/468831468340807129/world-development-report-1993-investing-in-health>

20 Mackintosh, M., and Koivusalo, M., edited by (2005). *Commercialization of Health Care. Global and Local Dynamics and Policy Response*. Basingstoke, Palgrave Mcmillan, 2005, <https://digitallibrary.un.org/record/573055?ln=en>.

21 <https://www.msf.org/8-ways-user-fees-health-are-harmful-people>

in low-and middle-income countries. When the report was published, the model of formal, for-profit health care provision had been mostly limited to high-income countries. It took less than a decade for private capital to flood across global health governance, financing, and provision of healthcare.

The transition has largely been pursued through the progressive dismantling of welfare systems (where they existed), devolving service provision for the people lacking purchasing power to the voluntary and non-profit sector, and mixing the public and private sector in healthcare. Over three decades, Public-Private Partnerships (PPPs) have been promoted as a method of high potential among the instruments of blended finance to overcome inefficiencies in public health expenditures. Although PPPs have been more commonly implemented in OECD countries, as lower income countries were perceived less attractive for large private investors, the embrace of partnerships with the business sector by the United Nations system has largely resulted in incentivizing PPP initiatives in the global South. The Millennium Development Goals (MDGs) agenda operated as the testing ground for the interests and practices of the private sector beginning to play a larger role in global public health (MDG8). New forms of cooperation and interventions were imposed, while humanitarian schemes and health system projects made common cause with the private sector's technical and financial know-how.

This complex mix of partnerships has arisen to all-embrace the health development agenda, in a sort of *projectification* of care²². The model, now enshrined in the design and implementation of the Sustainable Development Goals (SDG) agenda, has universalized PPPs as *the* paradigm for international development²³ and global health (SDG17). In two decades, PPPs' fetishism has institutionalized corporate actors' pervasiveness in global health decision-making²⁴. The shift has occurred with virtually no public oversight and no consideration of the risky spillover effects that this strategy produces regarding compatibility with the UN mandates²⁵.

22 Meinert, L., Reynolds Whyte, S., (2014). Epidemic Projectification: AIDS Responses in Uganda as Event and Process. In *Cambridge Anthropology*, 32(1), Spring 2014:77-94, doi:10.3167/ca.2014.320107. Also, in this regard, Meinert, L., (2013). Therapeutic clientship: belonging in Uganda projectified landscape of AIDS care. When people come first. In *Researchgate*, January 2013, https://www.researchgate.net/publication/320101325_Therapeutic_clientship_belonging_in_Uganda's_Projectified_Landscape_of_AIDS_CareWhen_People_Come_First/link/59ce16abaca272boec1a4905/download

23 <https://blogs.worldbank.org/ppps/short-history-ppps-development-good-bad-and-hopeful>

24 Richter, J., (2004). Public-Private Partnerships for Health: A Trend with no Alternatives?. In *Development*, 47(2): 43-48, <https://link.springer.com/article/10.1057/palgrave.development.1100043>

25 Adams, B., (2016). United Nations and Business Community: Out-Sourcing or Crowding in?. In *Financing for Development*, Development 59:21-28, <https://link.springer.com/article/10.1057/s41301-017-0070-4>

4 - PUBLIC-PRIVATE PARTNERSHIPS NOT GOOD FOR HEALTH

Since the new millennium, intense political resolve has been directed towards functional public and private partnerships (PPPs), considered a logical response to the structural changes in the state-market relations brought about by globalization, with the rolling back of state responsibilities and the massive growth of corporate power. The newfound faith in private law schemes has spread to become a global phenomenon. Developing countries have been quick to jump on the privatization bandwagon, sometimes as a matter of political and economic ideology, other times simply to raise revenue.

PPPs embody a remarkable governance shift from institutional set-ups based on formal structures and traceable lines of responsibilities to functional initiatives or contracts based on voluntary approaches. They are promoted as a vehicle to leverage private finance and are surrounded by claims that the private sector is more efficient and cost/effective in the delivery of public services. The international development community has engaged in a myriad of initiatives to nurture reforms in national regulatory frameworks and usher the feasibility of PPPs in this way, including by providing advice and funding for PPP projects. Whereas the sudden mushrooming of these initiatives is linked to the UN reform and the implementation of the UN Global Compact²⁶, it is also heavily related to the efforts by the World Bank and multilateral development banks to advance this model to prioritize the private sector's over public or concessional finance, with a strong push to reduce financial risks for investors to come in²⁷. In other words, PPPs have easily become the silver bullet for the new "Wall Street Consensus"²⁸.

PPPs greatly vary in genesis, structures and purpose, and are encouraged as the most efficient shortcut to the shortfall in financing required to implement the SDGs. Beyond the narrative, still not backed by solid institutional evidence, PPP projects have been vastly procured with the ultimate purpose of circumventing budget constraints and postponing fiscal costs' recordings. Accounting practices allow for governments to keep the costs of PPP initiatives and their contingent liabilities "off balance sheet", disregarding the fact that such procedure exposes public finance to fiscal risks. At the same time, the ongoing insistence on austerity measures and on strict policy recipes that impose a low fiscal deficit²⁹ contribute to creating a wrong-headed incentive in support of PPPs.

It is difficult to underestimate the governance hazards that come with the institutional

26 <https://unglobalcompact.org>

27 <https://www.eurodad.org/historyrepeated2>

28 Gabor, D., (2021). The Wall Street Consensus. In *Development and Change*, 26th March 2021, <https://onlinelibrary.wiley.com/doi/full/10.1111/dech.12645>

29 <https://www.oxfam.org/en/press-releases/every-1-imf-encouraged-set-poor-countries-spend-public-goods-it-has-told-them-cut>

hybridization³⁰ embedded in most PPPs, particularly when private-law, market-based approaches are supposed to deliver public goods, against standards of legitimacy set under public law. In the health field, evidence gathered by researchers reveals a reality that challenges the dogmas of this fettered model, and its optimism bias. Policy debate in this field is particularly indebted to the activity carried out by civil society entities and local communities, which have played a key role in measuring and assessing PPPs' misrepresentation and broken promises. The breakthrough story of the Queen Mamohato Memorial Hospital (QMMH) built in Lesotho, the first PPP for a hospital in Africa and a marketed flagship to be replicated in the continent³¹, stood out as a pioneering example of how PPPs could result in diversion of scarce resources away from primary health care services in rural areas of low-income countries, where needs are dire³². Oxfam's investigation has raised a vigorous debate in past years on the QMMH - a building like no others in the impoverished country³³. Those preliminary concerns about the cost of the hospital's services and their impact on health provision are confirmed in a recent longitudinal study of the PPP in Lesotho, where high occupancy rate and outpatient demand have since the beginning strained the relationship between the government and the private partner overpayment for services provided in over contract maximums³⁴.

Let's move to Kenya. Scrutiny by the Institute of Economic Affairs (IEA) of Kenya of the seven-year leasing of medical equipment project – Managed Equipment Services (MES) – has found conspicuous cost variations in its operationalization with the six different private firms engaged. From the originally agreed Ksh 38 billion, the project costs went up to Ksh 63 billion four years down the line. Moreover, "due to transparency issues, including access to important documents such as the project contract, it was unclear whether the project cost is inclusive of suppliers' obligations, beyond supply and installation of equipment, including training, repairs and replacement, and insurance costs"³⁵. As of February 2023, the National Treasury's budget policy statement indicated that Ksh 5.9 billion had been allocated to MES. In April 2023, IEA and other civil society groups came out again to publicly oppose the Kenyan government's intention to extend MES, arguing that the plan would entail falling again into the pit where billions of taxpayers' money was lost, while MES disclosed operational gaps and potential legal violations had remained unaddressed³⁶.

30 Utting, P. and Zammit, A., (2006). Beyond Pragmatism: Appraising UN-Business Partnerships. UNRISD, Markets, Business and Regulation Programme Paper No. 1, October 2006, <https://www.yumpu.com/en/document/read/27643472/beyond-pragmatism-appraising-un-business-partnerships/23>

31 <https://www.worldbank.org/en/country/lesotho/brief/lesotho-health-network-ppp>

32 <https://policy-practice.oxfam.org/resources/a-dangerous-diversion-will-the-ifcs-flagship-health-ppp-bankrupt-lesothos-minis-315183/>

33 Webster, P.C., (2015). Lesotho's controversial public-partnership project. In *The Lancet*, 14th November 2015, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)00959-9/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00959-9/fulltext)

34 Scott, N.A., Kaiser, J.L, Jack, B.W, et al., (2022). Observational study of the clinical performance of a public-private partnership national referral hospital network in Lesotho: Do improvements last overtime? in *Plos One*, 28th September 2022, <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0272568>.

35 <https://ieakenya.or.ke/download/eight-facts-on-the-medical-equipment-leasing-project-in-kenya>

36 <https://www.pd.co.ke/news/civil-groups-want-state-to-act-on-gaps-in-mes-project-177860>

Although the private sector service arrangement has been confirmed to be unstable and ill-suited to service continuity³⁷, calls for increasing the role of the private sector in the financing of health infrastructures and public services, and for PPPs as the operational model, remain a priority. The literary production on health PPP initiatives scattered in the world has helped disclose the highly controversial issues that are to be found in industrialized countries, too. As featured by Eurodad analyses, in 2010 Swedish authorities attributed single bidder the Swedish Hospital Partners (SHP) a PPP contract to construct and operate the Nya Karolinska Solna (NKS) Hospital. Based on evaluations commissioned by the European Commission (EC), the decision to go for a PPP was guided by the conviction that this procurement model would bring “three potential benefits”: “certainty of costs, certainty to deliver, and better value”. This decision followed specific indications from consulting firms PwC (2007) and Ernest & Young (2008)³⁸. NKS was meant to be “one of the world’s most advanced hospitals” and is now known as the “most expensive hospital in the world”³⁹. While the initial cost of the construction was in the reason of Kr 14.5 billion (€1.4 billion) and the total life cycle cost approximately Kr 52.5 billion (€5 billion), media investigations uncovered that the real hospital bill would exceed Kr 25 billion (€2.4 billion), with projected total expenses reaching Kr 61.4 billion (€5.89 billion) until 2040⁴⁰. The increase stemmed from the fact that the construction costs had not included all the outsourced expenditures and the interest rates, the property maintenance costs and the private actor’s expected profits⁴¹. The scandal went beyond cost implications, to include delays in the program delivery, hidden fiscal boxes built in Luxemburg via the consulting firms, and severe political repercussions in the country. Not a great deal, after all!

Similar dynamics have been disturbingly spotted at the height of the pandemic in Scotland and Spain⁴². Italy, the fist epicenter of the pandemic in Europe, has for its part emerged as a spectacular example of the negative externalities associated with public-private arrangements in the health sector, a *privatocracy*⁴³ mode used at the expense of public service provision⁴⁴. It is tragic that the highly privatized healthcare of Lombardy,

37 Williams, D.O., Yung, K.C., et al., (2021). The failure of private health services: COVID-19 induced crises in low- and middle-income country (LMIC) health systems. In *Global Public Health*, 2021 Aug-Sep;16(8-9):1320-1333, <https://pubmed.ncbi.nlm.nih.gov/33471633/>.

38 Romero, M.J., (2018). History RePPPeated: How public-private partnerships are failing. Eurodad Report, October 2018, pp. 17-19, https://assets.nationbuilder.com/eurodad/pages/508/attachments/original/1590679608/How_Public_Private_Partnerships_are_failing.pdf?1590679608

39 *Ibidem*

40 *Ibidem*

41 *Ibidem*

42 Blavot, O., (2022). History RePPPeated II: Why public-private partnerships are not the solution. Eurodad Report, December 2022, pp. 19-24, https://assets.nationbuilder.com/eurodad/pages/3071/attachments/original/1671445992/01_history-rePPPeated-2022-EN_19dec.pdf?1671445992

43 https://docs.marionegri.it/website/Convegno_Privatocrazia_save%20the%20date.pdf

44 Toth, F., (2023). The Public/ Private Sector Mix in the Italian Healthcare System. In *The Public/ Private Sector Mix in Healthcare Delivery*. Edited by Howard Palley, A., Oxford University Press. © Oxford University Press 2023. DOI: 10.1093/oso/9780197571101.003.0008

one of Europe's wealthiest regions and one of the world's highest COVID-19 mortality hotspots, should be showcased as a reference practice of private sector's engagement by the World Health Organization (WHO) as late as December 2020⁴⁵.

Recent findings of the first ever WHO report on Public-Private Partnerships for healthcare infrastructure and services⁴⁶, examining evidence of PPPs in the middle-income countries in the European region, seem to convey a more problematic sense of reality. The WHO empirical analysis, while continuing to endorse PPPs as a mode for mobilizing additional capacity that demonstrates occasional benefits, largely confirms perplexities brought out by civil society studies in terms of allocative efficiency, financial and transaction implications, as well as fiscal governance, acknowledging that "the obligations created by PPPs for the public sector and other health system stakeholders are debt-like, in that they cannot legally be avoided or adjusted and can undermine the financial sustainability of health systems". The opportunity to defer and smooth out costs throughout PPPs can create budgetary incentives in the public sector, but PPPs' long-term nature becomes a significant portion of the risk transfer on the public sector, in a complexity accruing in unpredictable ways while private capitals' investors gain the financial profits and the power that stems from the privatization of governance.

The WHO diagnosis is welcome, except that the prescriptions contained in the report for resolving the key externalities identified in the various PPPs in Europe confirm the agency's ideological and policy retreat from the notion of publicly provided healthcare. WHO insists that government authorities must equip themselves with strong capacities aimed to undertake these initiatives and manage them properly. Governments must make intentional investment, says the WHO, in specialized human resources and needed administrative skills to tailor contracts, maintain negotiating capacity with the private sector, and fulfil the public tasks⁴⁷, among other things. But is this realistically the way to go? WHO recommendations overlook how hollowed-out governments are when tackling their multiple dependencies with financial institutions that literally impose PPPs. The report willfully ignores the unique power that big consulting firms wield through their extensive contracts and networks of advisors, legitimators and outsourcers, and how they can infantilize governments with the illusion that they are objective sources of expertise and capacity⁴⁸. PPPs, with few exceptions, are made to weaken state legitimacy, as public service provision loses its *visibility* and the state loses its *proximity* with its citizens. The material distance fuels mistrust in institutions and a perilous democratic void⁴⁹.

45 World Health Organization (2020). *Engaging the private health service delivery sector through governance in mixed health systems: strategy report of the WHO Advisory Group on the Governance of the Private Sector for Universal Health Coverage*. WHO, Geneva, December 2020, <https://www.who.int/publications/i/item/9789240018327>

46 <https://www.who.int/europe/publications/i/item/9789289058605>

47 *Ibidem*, pp. 45-47

48 Mazzucato, M., (2023). *The Big Con: How the Consulting Industry Weakens our Businesses, Infantilizes our Governments and Warps our Economies*, Penguin Ltd., London, April 2023.

49 Cordelli, C. (2020). *The Privatized State*. Princeton University Press, November 2020.

5 - COVID-19: THE PUSH FOR HEALTHCARE AS MARKETPLACE FOR PRIVATE INVESTORS

In 2015, international financial institutions and the G20 announced a new vision of international development deemed necessary to achieve the UN-mandated SDGs and focused on private finance. From the Billions to Trillions agenda⁵⁰ (2015) to the World Bank's Maximizing Finance for Development initiative (2017)⁵¹ to the G20 Infrastructure as an Asset Class agenda⁵², the aspiration to turn development finance into profitable business is unchallenged. The World Bank was adamant that, in the new trajectory, countries should be aiming at the trillions held by institutional investors and asset managers:

What will it take? Essentially, knowledge, financing, and partnership. The first exists in abundance. While ongoing technological and conceptual breakthroughs will undoubtedly help, we already have sufficient experience, know-how, and technical expertise to remedy the biggest problems that afflict the world's poor, under-served and vulnerable. The problem is how to finance these solutions and how to come together in partnership to implement them speedily and effectively when and where they are needed⁵³.

Apart from the "master of the universe" culture reflected in the quote, not the topic of this work, we cannot avoid considering that tapping the trillions of global institutional investors entails, particularly for low-income and indebted countries, reengineering their financial policies and systems. The reshape is necessary to adapt to market-based finance on the terms of those investors, creating a pipeline of profitable projects, mainly by removing investment risks. De-risking is at the heart of what is called blended finance, "the strategic use of development finance for the mobilization of additional private investment towards sustainable development"⁵⁴. Through this mechanism, concessional public money is combined with non-concessional private funding and expertise to now finance considerable portions of the 2030 Agenda⁵⁵. The amalgamation - it's worth emphasizing - provides *the use of public finance* to guarantee forms of compensation to private investors in case their investment does not go well. Taxpayers' money, in other words, is used to convince them that their financial operations will ensure the expected returns. Lowering the risk bar decreases interest rates, and low-rate loans enable providers to expand their services more easily.

50 <https://pubdocs.worldbank.org/en/622841485963735448/DC2015-0002-E-FinancingforDevelopment.pdf>

51 [https://www.worldbank.org/en/region/eca/brief/programs#:~:text=Maximizing%20Finance%20for%20Development%20\(MFD\)%20is%20the%20World%20Bank%20Group's,support%20developing%20countries'%20sustainable%20growth](https://www.worldbank.org/en/region/eca/brief/programs#:~:text=Maximizing%20Finance%20for%20Development%20(MFD)%20is%20the%20World%20Bank%20Group's,support%20developing%20countries'%20sustainable%20growth)

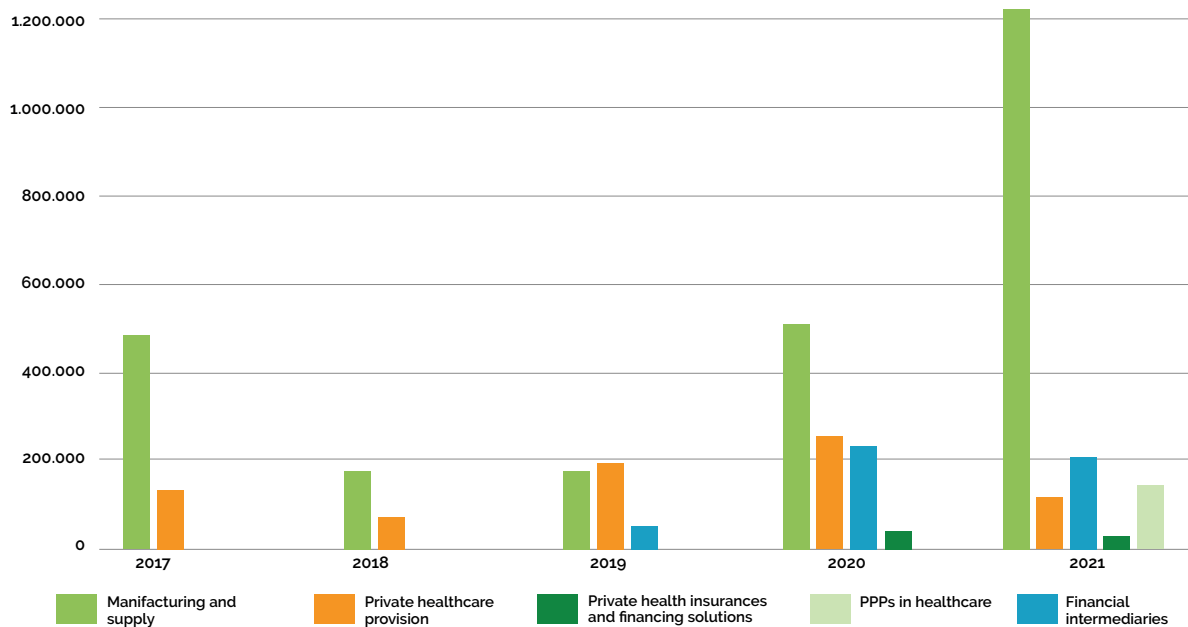
52 https://www.oecd.org/g20/roadmap_to_infrastructure_as_an_asset_class_argentina_presidency_1_0.pdf

53 <https://blogs.worldbank.org/voices/billions-to-trillions-financing-the-global-goals>

54 <https://www.oecd.org/dac/financing-sustainable-development/blended-finance-principles>

55 <https://www.eurodad.org/blended-finance-briefing>

Covid-19 has enhanced demand for public sector to incentivize commercial activities to “modernize” and digitize health services, while meeting funding gaps. The idea behind this demand is also to trigger new thinking and engagement on domestic production of key health services. The International Finance Corporation (IFC), the private sector’s arm of the World Bank⁵⁶, has been at the forefront of facilitating the financialization of health sectors, particularly in low-middle income and middle-income countries. It has launched a US\$4 billion medical supply platform⁵⁷ and the Real Sector Crisis Response Facility⁵⁸, through which it has escalated its investments in national health systems⁵⁹. Under this latter instrument, refinancing and stability loans have flown to private sector providers and other wider private sector businesses and banks, transforming healthcare systems in profitable zones for global capital during the pandemic and largely helping the sector’s deregulation to achieve the SDG target of Universal Health Coverage (UHC)⁶⁰. After 2020, health financing has grown from 1.6% of IFC overall spending in 2019 to 5.5% in 2021⁶¹.



Source: Wemos

56 The International Finance Corporation (IFC) is the World Bank’s private equity investment arm, aimed at unlocking private investment, creating markets and opportunities in low and middle income countries, https://www.ifc.org/wps/wcm/connect/corp_ext_content/ifc_external_corporate_site/about+ifc_new

57 <https://reliefweb.int/report/world/ifc-helps-businesses-poorest-countries-fight-pandemic-4-billion-covid-19-financing>

58 <https://documents1.worldbank.org/curated/pt/166621584551201643/pdf/Report-to-the-Board-of-Directors-on-a-Proposed-Investment-in-IFC-Fast-Track-Covid-19-Facility-World-Region.pdf>

59 <https://sites.google.com/view/ifchealthprojectstracker>

60 Hunter, B.M., Murray S.F., (2019). Deconstructing the Financialization of Healthcare. In *Development and Change*, Volume 50, issue 5, pp. 1263-1287, <https://onlinelibrary.wiley.com/doi/full/10.1111/dech.12517>

61 <https://www.wemos.nl/wp-content/uploads/2022/04/Improving-healthcare-but-for-whom.pdf>

According to Data Bridge Market Research analyses in 2022, the healthcare finance solutions market is projected to rise at a compound annual growth rate (CARG) of 8.40% in the forecast period of 2022-2029 and is likely to reach the USD 194.96 billion by 2029⁶². Healthcare finance solutions, in the research group's definition, is "a collection of financial capital solutions that allow parties to mobilize cash to address a variety of healthcare demands, including funding for medical equipment, infrastructure upgrades, treatment coverage, and a variety of other things". In its own terms, the group sheds key interpretative lights in between the lines of multilateral circles' sustainable development rhetoric:

The rising demand for constant upgradations and modifications in different healthcare processes with the purpose of improving performance of various healthcare facilities will act as major driver accelerating the healthcare finance solutions market's growth rate. The rising adoption rate of hi-tech equipment and technology will increase the demand for healthcare finance solutions and further propel the market's growth rate. Another significant factor resulting in the expansion of market is the presence of favourable government initiatives for the development of healthcare infrastructure. Furthermore, surging healthcare expenditure and increase in digital adoption in healthcare sector are the major drivers that will enhance the growth of market. Rapid urbanisation, changing lifestyle and rise in the level of disposable incomes in developing and developed countries will influence the growth rate of healthcare finance solutions market. The rise in the number of geriatric populations, the rise in prevalence of chronic disorders and increase in the demand for early diagnosis will flourish the growth rate of healthcare finance solutions market⁶³.

After the pandemic, a rampant community steered by the World Bank with new alliances of public and non-state actors – national governments, the Bill and Melinda Gates Foundation, private investment corporations, the IFC - has championed escorting new capital to frontier markets, where it is free to perform the mundane activity of converting arenas of public law obligations into easy pastures for financial flows. Private investors and healthcare concerns as natural bedfellows, this is the misleading assumption.

The notion of a win-win outcome between health and financial returns enshrined in blended finance arrangements create considerable confusion in terms of governance and operational defaults. Financialization draws new people and places into the financial arena, reconfiguring roles and relationships often in uneven fashions⁶⁴. Private investors are obviously inclined to select healthcare areas that are less risky and most rewarding,

62 <https://www.databridgemarketresearch.com/reports/global-healthcare-finance-solutions-market>

63 <https://www.databridgemarketresearch.com/reports/global-healthcare-finance-solutions-market>

64 Pike, A., and Pollard, J., (2010). Economic Geographies of Financialization. In *Economic Geography*, Volume 86, No.1, January 2010, pp. 29-52, Taylor & Francis, <https://www.jstor.org/stable/27806894>

and their provision of healthcare is tailored for *affluent clients* in urban settings, where state-of-the-art healthcare facilities coexist with dilapidated public hospitals – a scenario that only used to be seen in low-income countries, while it has recently become visible in countries of the global North just as well. Evidence that concerns of investors tend to predominate at the detriment of public sector's priorities emerges from the civil society assessment of the implementation of the Dutch Aid & Trade agenda in the African healthcare context. One Wemos team has closely scrutinized a multi-hospital infrastructure development project carried out by Royal Philips in Tanzania⁶⁵ and the Dutch Life Science and Health Sector (LSH) seeking market expansion in Kenya⁶⁶, raising important - and still unanswered - questions about the interests *really* pursued by the government of the Netherlands through these operations.

More recently, Wemos and the feminist Pan-African development organization Akina Mama Wa Afrika (AMwA) have critically analyzed the Africa Medical Equipment Facility (AMEF), a facility that supports private healthcare providers in seven African countries to purchase medical equipment from manufacturers by de-risking loans provided by local banks⁶⁷. AMEF is the first World Bank's investment of its kind, in perfect coherence with Data Bridge projections. The announced intent is to promote equitable access, particularly for vulnerable populations, associated to maternal healthcare.

Medical equipment is certainly a WB priority, as we have seen, and it is surely needed in most African countries. However, one must question the value of such piecemeal interventions for people and their health, in countries that often lack healthcare personnel, but abound socio-economic determinants for ill health. What form of patienthood and health belonging takes shape when new medical technologies are deployed through global health interventions? The research shows that the AMEF facility is "mainly attractive for higher-end, medium to large private facilities, allowing them to access more financing to purchase medical equipment [...] and loans are unlikely to benefit small to low-ends healthcare providers"⁶⁸. How can donors, investors and governments be held accountable for the impact that such interventions will inevitably produce on health systems overtime, especially in financially volatile times and with landscapes of severe health inequalities?

65 https://www.wemos.nl/wp-content/uploads/2019/11/Wemos_discussion-paper_Aid-for-Trade_Best-Public-Value-for-Public-Money_Oct-2019.pdf

66 Gabor, D., (2019). *Securitization for Sustainability: Does it Help Achieve the Sustainable Development Goals?*. Heinrich Boell Stiftung, October 2019, p. 2. https://us.boell.org/sites/default/files/gabor_finalized.pdf

67 AMEF is financially backed by the Global Financing Facility for Women, Children and Adolescents (GFF) and the International Financial Corporation (IFC), the private sector arm of the World Bank. The facility's goal is to enhance healthcare provision, foster innovation and increase investment in the private health sector by demonstrating its bankability. Kenya and Ivory Coast are the first two countries where AMEF is being implemented. <https://disclosures.ifc.org/project-detail/SII/46659/amef-rsf-bbgci>

68 https://www.wemos.nl/wp-content/uploads/2022/12/Study-of-the-Africa-Medical-Equipment-Facility-in-Kenya_2022.pdf

6 - DOUBLING DOWN ON NEOLIBERAL POLICIES

While the rhetoric of blended finance with the purpose of “leave no one behind” collides with empirical evidence of its use in real life, key lessons from COVID-19 remain systematically ignored. Since its inception, the pandemic has quickly illustrated multiple and catastrophic instances of market failure in private health services globally, with serious implications for the pandemic response⁶⁹. At the multilateral level, this failure has resulted in a path-dependent global governance failure, with insistence on further embedding the role of private finance and markets in health systems as the primary channel for steering economic growth in the developing world⁷⁰.

The COVID-19 has not generated any retreat from private health and from the partnership model that has defined engagement with and promotion of private health in the last two decades. Neoliberal policies remain too deeply entrenched in the multilateral development institutions that arbitrate global health policy for them to even conceive reorienting the *private first* approach towards more equal and sustainable financial policies. Instead of changing course, they appear to double down on neoliberal commitments⁷¹.

The World Bank is currently preparing for big and long-awaited reforms, as disclosed in a new Evolution Roadmap published in early 2023⁷². The paper spells out the approach that the World Bank Group (WBG) will adopt, while keeping its focus on poverty reduction and shared prosperity, to address “the crisis of development” which has resulted in new poverty and economic distress, climate change, rising fragility and conflict, and of course pandemic risks. The report was created in the wake of mounting pressure from the World Bank’s shareholders about the need for multilateral development banks to increase their fire power amidst a deteriorating global economic scenario. The WBG roadmap has no clear targets or timeframe to address global challenges, but what it clearly projects is an iteration of existing strategies, with repeated emphasis on increasing lending and de-risking private finance for developing countries: “rather than tackling the systemic causes of these obstacles, and shoring up countries’ capacity to raise domestic revenue, the current reform agenda will open the door to more lending, further inflating the already extraordinarily high debt levels”, as highlighted by Jean Saldanha, Eurodad Director⁷³.

69 Williams, O.D., (2020). COVID-19 and Private Health: Market and Governance Failure. In *The World Needs Healthy Commons*. Development, Volume 63, number 2-4, December 2020, Society for International Development (SID), <https://link.springer.com/article/10.1057/s41301-020-00273-x>

70 Mawdsley, E., (2018). Development Geography II: Financialization. In *Progress in Human Geography*, Vol. 42 (2), 264-274, 2018, <https://journals.sagepub.com/doi/pdf/10.1177/0309132516678747>.

71 Sparke, M., Williams, O.D., et al., (2021). Neoliberal disease. COVID-19, co-pathogenesis and global health insecurities. In *Sage Journals*, Volume 54, Issue 1, October 2021, <https://journals.sagepub.com/doi/10.1177/0308518X211048905>

72 <https://www.worldbank.org/en/news/statement/2023/01/13/world-bank-group-statement-on-evolution-roadmap>

73 https://www.eurodad.org/springs_reaction_2023

The quite surreal assumption that private sector solutions and financing are functional to the production of global public goods like climate change or pandemic preparedness pervades the roadmap report. The WBG builds on this narrative announcing the exploration of additional financial innovations, including new sustainability bonds, securitization platforms, and broadened scope and amount of concessional blended finance - among others - to mobilize private capital and maximize development resources. The idea is "reserving scarce public financing for those areas where private sector engagement is not optimal or available"⁷⁴.

SECURITIZATION FOR HEALTH?

Securitization is the transformation of streams of future income into a financial security ready to sell immediately and can be applied to anything with a regular income; (thinking about healthcare) water services, *sustainable* hospital management, governments' loans. Envisaging securitization – selling development finance to the market, as we have seen in past years with social impact bonds⁷⁵ and pandemic bonds⁷⁶ – as a central de-risking instrument to achieve SDG ambitions opens up new complex forms of financialization in the health field. Securitization implies that financial actors are constantly looking for new sources of future income to transform, meaning that a securitization-based SDG agenda presents multiple risks in terms of perpetuating social and developmental inequities⁷⁷, with massive health consequences.

Economist Daniela Gabor explains that the turn which has lately been announced in the evolution roadmap would not only reorient the WBG's mission from concessional to commercial lending, thereby shifting the terms of the relationship between multilateral development banks and private finance, but it would also encourage the further "(indirect) privatization of public services, necessary to both generate and de-risk cash flows that can be directed to the owners of securities"⁷⁸. Evolution reforms can certainly do better than that.

74 <https://www.worldbank.org/en/news/statement/2023/01/13/world-bank-group-statement-on-evolution-roadmap>, 31, p. 10.

75 Hulse, E.S.G., Atun, R. et al., (2021). Use of social impact bonds in financing health systems response to non-communicable diseases: scoping review. In *BMJ Global Health*, 2021;6:e004127, <https://pubmed.ncbi.nlm.nih.gov/33674267>

76 Brim, B. and Wenham, C., (2019). Pandemic emergency financing: Struggling to deliver on its innovative promise. In *The British Medical Journal*, 367, October 2019, <https://doi.org/10.1136/bmj.l5719>

77 Gabor, D., (2019). *Securitization for Sustainability: Does it Help Achieve the Sustainable Development Goals?*. Heinrich Boell Stiftung, October 2019, p. 2, https://us.boell.org/sites/default/files/gabor_finalized.pdf

78 *Ibidem*, p.2.

7 - HEALTH FINANCIALIZATION THROUGH BOND SCHEMES

Health related bonds have become an attractive tool of innovative financing, and an increasing phenomenon, including during the COVID crisis, after the Global Alliance for Vaccine Immunization (GAVI) championed its vaccines bonds through the International Finance Facility for Immunization (IFFIm)⁷⁹. Since its launch in 2006, IFFIm has played a pioneering role in developing social bonds and funding global health, securing US\$7.9 billion from investors and US\$8.9 billion in donor commitments (as of July 2022) spanning 32 years, with disbursement of over US\$3 billion to GAVI to date. Since its inception, this innovative finance scheme has been heralded as a catalytic success story, a game changer for global immunization. The IFFIm model has served as an inspiration for other development fields (like education) and is now seen as a key strategy to mobilize the trillions deemed indispensable to meet the SDG agenda. Enough of a reason to give it a serious sober look.

In practice, IFFIm issues vaccine bonds in capital markets, supported by long-term legally binding commitments from donor countries. The capital collected from institutional and private investors is used to finance GAVI immunization and health system strengthening programs. The financial model of this prime example of social bonds and socially responsible investment is quite complex and reveals a network of players that are close interconnected through a thick canvass of financial flows⁸⁰.

WHAT FUTURE FOR PANDEMIC BONDS?

Pandemic bonds materialize the distinctive acceleration and deepening of the “financialization-development nexus”⁸¹, as the financial sector engagement for poorest countries is increasingly considered by mainstream development thinkers a desirable landscape. These financial instruments, tailored after catastrophe bonds that pay out in response to events like floods or hurricanes, are purposed to disburse large amounts of money to countries with fragile health infrastructures more quickly than traditional financial mobilization and coordination methods. One entity – for example, the World Bank - issues a bond that pays interest to the investors over time. If determined conditions to trigger the bond occur, the moneyed capital from the bond sale is *quickly* funnelled to medical efforts to contain and quell the disease outbreak. The time factor is key,

79 <https://www.gavi.org/investing-gavi/innovative-financing/iffim>

80 Hughes-McLure, S., Mawdsley, E., (2022). Innovative Financing for Development? Vaccine Bonds and the Hidden Cost of Financialization. In *Economic Geography*, 98:2, 145-169, <https://www.tandfonline.com/doi/full/10.1080/00130095.2021.2020090>

81 Mawdsley, E., *op. cit.*, p. 265.

at least in principle; affected regions need not wait for aid money to be raised and coordinated. Pandemic bonds are not triggered by losses, as in the case of the "indemnity triggers" of catastrophe bonds, but rather by the actual, real time spread of the disease. This implies, at least in theory, that capital can flow much faster than if it had to wait until insurance losses began rolling in. Capital flow's speed to emergency response (health clinics, aid workers, health personnel, contagion containment efforts) is crucial in the case of pandemics. Pandemic bonds were introduced by the World Bank in response to the Ebola outbreak in 2014 and aim to create a market for pandemic risk insurance. The WB inaugural 2017 issuance⁸² covered 6 viruses (new influenza pandemic virus A, SARS, MERS, Ebola, Marburg, and other zoonotic diseases like Crimean Congo, Rift Valley, Lassa Fever).

Private investors develop the appetite to underwrite products that offer protection against future pandemics and to purchase pandemic bonds to diversify their investments, and due to the high coupon rate - 6.9% for tranche A covering flu and coronavirus and 11.9% for the riskier tranche B, covering zoonotic diseases - and the high returns promised in exchange for the risks of a pandemic. However, the structure of the bond issuance has set an array of complex and rigid trigger arrangements that have slowed down the release of funds and exposed these inaugural bonds to increasing criticism within and beyond the health sector⁸³, while making these high-yielding instruments less attractive to investors⁸⁴. Alternative pandemic financial approaches are being considered, that may better respond to the demand for expeditiously mobilizing adequate funds to countries in need, including in the context of the WB Pandemic Fund⁸⁵ and the WHO negotiation on a pandemic treaty⁸⁶. The scheme adopted by GAVI through its IFFIm vaccine bonds is consistently regarded a useful framework that could be replicated, to overcome past challenges - and failures - of pandemic bonds.

Using the "follow the money" methodology for their research, Hughes-McLure and Madwsley have accurately illustrated IFFIm as a glaring example of development financialization, and finance expanding and deepening its reach into the domain of global health⁸⁷.

82 <https://www.worldbank.org/en/news/press-release/2017/06/28/world-bank-launches-first-ever-pandemic-bonds-to-support-500-million-pandemic-emergency-financing-facility>

83 Brim, B. and Wenham, C., (2019). Pandemic emergency financing: Struggling to deliver on its innovative promise. In *The British Medical Journal*, 367, October 2019, <https://doi.org/10.1136/bmj.l5719>

84 <https://www.ft.com/partnercontent/calvert/after-covid-19-the-future-of-pandemic-bonds.html>

85 <https://fiftrustee.worldbank.org/en/about/unit/dfi/fiftrustee/fund-detail/pppr>

86 <https://www.who.int/news/item/03-03-2023-countries-begin-negotiations-on-global-agreement-to-protect-world-from-future-pandemic-emergencies>

87 Hughes-McLure, S., Mawdsley, E., (2022). Innovative Financing for Development? Vaccine Bonds and the Hidden

A plethora of financial actors are enrolled to implement the economic geography of the IFFIm mechanics, which have been largely conceptualised and designed by credit rating agencies to securitize aid provided by donor countries – public financial commitments are leveraged through financial markets. The strong influence of these agencies has resulted in setting several strict financial limits on operations to manage risk, all aimed at mitigating risks for investors. The sophisticated arrangement weakens public control, the researchers claim, while at the same time peeling off donor governments' funding for private investors, including in the form of interest costs of borrowing from capital markets and fees to financial organizations and professional services. As of 2019, the equivalent of 30% of the \$3.1 billion taxpayers' payments to IFFIm has been channeled this way⁸⁸. The rather impenetrable interplay of key individuals and institutions that IFFIm relies on, "already networked in webs of politics and finance"⁸⁹, converge on a mould that ultimately not only limits political oversight but also ring-fences public money: "IFFIm's design could be said to weaken democratic decision-making by foreclosing policy options available to future governments. Once grant agreements, which are long term (often lasting fifteen to twenty years) and large in scale (usually hundreds of millions of dollars and sometimes over \$1 billion) have been signed, they are irrevocable legally binding commitments of future governments"⁹⁰. This has significant opportunity costs.

It is remarkable that despite important global storms like the financial crisis in 2008 and the more recent pandemic, IFFIm has continued to operate according to its original design, unlike other health-related bonds that have demonstrated embarrassing inefficiency – and alarming cynicism⁹¹. It is a fact is that this vaccine bond scheme has not been subjected to much scrutiny across the years. Thanks to the forensic analysis conducted by Hughes-McLure and Madwsley, it has finally been possible to measure how IFFIm's claims – frontloading mandate, low funding costs, private sources catalyzing capacity - do not quite match with the debt-driven financial logic of the mechanism, and with its real figures. These, indeed, reveal that "the financing model creates significant opportunities for private profit hiding in plain sight". Indeed, IFFIm's financial management and rewards are closely aligned with the economic and political geography of the initiative, seeded originally by the UK Chancellor Gordon Brown⁹². The specific spatial political structure of IFFIm is unsurprisingly centred around the UK. Around London, in fact, one of the world's top financial centres. This is where strategies were hatched, and decisions are still being made, the study shows. Similarly, bond issuance operations are conducted by financial institutions that are predominantly based in the UK, or in the global

Cost of Financialization. In *Economic Geography*, 98:2, 145-169, <https://www.tandfonline.com/doi/full/10.1080/00130095.2021.2020090>

88 *Ibidem*, p. 160.

89 *Ibidem*, p. 154.

90 These criteria for long-term pledges are not constitutionally applicable for some countries, the reason why the US is not a donor to IFFIm. *Ibidem*, p. 156.

91 Brim, B. and Wenham, C., (2019). Pandemic emergency financing: Struggling to deliver on its innovative promise. In *The British Medical Journal*, 367, October 2019, <https://doi.org/10.1136/bmj.l5719>

92 Sturcke, J., (2005). Brown launches global vaccine scheme. In *The Guardian*, 9th September 2005, <https://www.theguardian.com/uk/2005/sep/09/development.internationalaidanddevelopment>

North, while state actors and technical advice from the countries that are supposed to be IFFIm's beneficiaries are not present:

The financialization of global health and development is shaping economic geographies.

In which material rewards are distributed unevenly, concentrating in a (small number of) financial centres in the Global North. Vaccine recipients in the Global South, immunization delivery programs, and aid, become connected to global financial flows, which [...] distribute returns in a particular, uneven pattern. Similarly the decision making power and influence over financial flows, which rests with the actors that make up IFFIm's financing model, namely bondholders, financial institutions, professional services firms, are also connected to space and place in this uneven concentrated pattern. The result is material, social and political inequality".⁹³

There hardly seems to be anything innovative in this game-playing. Real innovation in tackling the problem of immunization and public health systems would require a significant Copernican turn towards financial justice reform⁹⁴. It would call for intentional efforts aimed to stop capital flights from low-income countries and immunize the broken international tax system⁹⁵, whereby the current and arguably most serious global crisis affects almost 60% of the poorest nations⁹⁶. That is the risk-scenario that threatens to nullify the development agenda, and that needs mitigating.

93 Hughes-McLure, S., Mawdsley, E., (2022), p. 163.

94 Dentico, N., Meurs, M., Aye, B. (2022). Financial Justice for Pandemic Prevention Preparedness and Response. Geneva Global Health Hub (G2H2), November 2022, Geneva, <https://g2h2.org/wp-content/uploads/2022/11/G2H2-Report-2022.pdf>

95 <https://unctad.org/news/blog-world-lacks-effective-global-system-deal-debt>

96 <https://www.brookings.edu/research/addressing-the-looming-sovereign-debt-crisis-in-the-developing-world-it-is-time-to-consider-a-brady-plan>

8 - CONCLUSIONS

Thirty years of health financialization and privatization have generated a pandemic of false solutions to the supposed lack of financial resources, and completely transformed the political strategies around health. While historically the modern administrative state was born to separate the public from the private, through exercise of an impartial administrative function, the state appears today an active player in financialization processes. Governments' decision-making capacity is increasingly skewed towards financial market interests⁹⁷. What we see is the reversal of the relationship between the state and the private sector, as it is enshrined even in the most pro-market constitutions⁹⁸. Health – as we have witnessed with pharma companies' profiteering on the pandemic – is the perfect ground for this paradoxical phenomenon, which has resulted in state-driven processes of state de-legitimation⁹⁹.

The financialization of health redirect public finance from the structural need countries face today to sustainably mobilize adequate domestic resources to fund healthcare, including policies aimed at effectively preventing and preparing for potential new pandemics. Reverting this course of things will be a long journey. In 2020, Covid-19 had lit the light of societal recognition to the importance of public health services and structures, to contain the contagion and manage the emergency. After the pandemic crisis, new forms of *public administration of private interests within the state*¹⁰⁰ have been asserted. With the blessing of the international community, a new architecture driven by a recently bred hierarchy of digital solutions is moving health securitization forward through the logic of *immunity* as the new organizing principle¹⁰¹.

Well before Covid-19, health financialization represented a new phase of capital formation, building on, but distinct from, previous rounds of privatization and neoliberal healthcare reform¹⁰². The health crisis has ushered a new pandemic binge for health financialization and triggered deeper questions, beyond the reductive analytical “outcome lens” about its performance. For example: to what extent can a government – when it increasingly looks and acts as a network of private actors - maintain the legitimacy of its primary public purpose?

Beyond the “regulatory capture”, the international community has decided to not

97 Cordelli, C. (2020). *The Privatized State*. Princeton University Press, November 2020.

98 Dosi, G., (2021). Policy Lessons from Medical Responses to the COVID-19 Crisis. In *Intereconomics*, 56, 337-340. <https://link.springer.com/article/10.1007/s10272-021-1009-2>

99 Cordelli, C. (2020). *The Privatized State*. Princeton University Press, November 2020.

100 Cordelli, C. (2020). *The Privatized State*. Princeton University Press, November 2020.

101 Dentico, N., (2021). The Breathing Catastrophe: COVID-19 and Global Health Governance. In *Development*, 2021; 64(1-2): 4-12. doi: [10.1057/s41301-021-00296-y](https://doi.org/10.1057/s41301-021-00296-y)

102 Hunter, B.M., Murray S.F., (2019). Deconstructing the Financialization of Healthcare, p.8.

wield decision-making authority in the global response to the first planetary health emergency, whose management has been treated as a release of market economy rationality¹⁰³. The clout exercised by an élite of global private actors in the response to the Covid-19 crisis has taken over the role normally played by governments, but without the accountability of governments¹⁰⁴. These dynamics have brutally shifted power further away from the state, while steadily advancing the parallel lives of intellectual property (IP) monopolies and financialized capitalism. The inequity of pandemic proportions that the world has witnessed in the distribution of Covid-19 vaccines through a new “super public-private partnership”¹⁰⁵ that is impossible to control has structurally manifested the “racialized health inequity” throughout the pandemic, and the direct link between Covid-19 and systemic racial injustice in the world¹⁰⁶. There are incredibly important issues of institutional transformation and democratic legitimacy¹⁰⁷ that must be addressed.

As the right to health is being redesigned to remain solidly ancillary to financial markets and inexorable privatization trends, the global public health community must urgently raise the visual spectrum beyond diseases and biomedical solutions to frontally address the speculative dynamics of finance advancing in the health sector. These have no promise of sustainability, except for private investors. Global organized reaction must be intentionally orchestrated to reverse the course of leveraging private finance and ensure that the benefits of public investment remain in public hands, to safeguard the nature of the public office space. The global campaign *The Future is Public*¹⁰⁸ is a first decisive step in the right direction, and must be strengthened, if we are to define what kind of world we want to live in.

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SID

Society for International Development

The Society for International Development (SID) is an international network of individuals and organizations founded in 1957 to promote socio-economic justice and foster democratic participation in the development process. It celebrates its 65th anniversary in 2022.

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SID's activities are facilitated by an International Secretariat with offices in Rome (headquarters) and Nairobi. The Development Journal (published by Palgrave Macmillan) has been SID's flagship publication for 65 years and enjoys broad readership within the development community.

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