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DOI:

[10.1111/dech.12517](https://doi.org/10.1111/dech.12517)

Document Version

Peer reviewed version

[Link to publication record in King's Research Portal](#)

Citation for published version (APA):

Hunter, B., & F Murray, S. (2019). Deconstructing the financialization of healthcare. *DEVELOPMENT AND CHANGE*, 50(5), 1263-1287. <https://doi.org/10.1111/dech.12517>

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Deconstructing the financialization of healthcare

User version accepted by Development and Change on 29th March 2019

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ACKNOWLEDGEMENTS

The research on which this article is based was funded by a Joint Health Systems Research Initiative grant (MR/R003009/1) with support from the UK Medical Research Council, Economic and Social Research Council, Department of International Development and the Wellcome Trust. An early version of this paper was discussed at the 2017 European Association of Development Research and Training Institutes (EADI) conference in Bergen, Norway. The authors are also grateful for the feedback from colleagues of the Social Justice research group in Department of International Development, and indebted to the journal's four anonymous peer reviewers for their guidance on the final version.

ABSTRACT

Financialization is promoted by alliances of multilateral 'development' organisations, national governments, and owners and institutions of private capital. In the healthcare sector, the leveraging of private sources of finance is widely argued as necessary to achieve the Sustainable Development Goal 3 target of universal health coverage. Employing social science perspectives on financialization, we contend that this is a new phase of capital formation. We trace the antecedents, institutions, instruments and ideas that facilitated the penetration of private capital in this sector, and the emergence of new asset classes that distinguish it. We argue that this deepening of financialization represents a fundamental shift in the organizing principles for healthcare systems, with negative implications for health and equality.

KEY WORDS

Development financing; health; UHC; private finance; private capital; investment

INTRODUCTION

The contemporary landscape of development is marked by growing roles for private sources of finance. These are often justified as a necessary strategy to fill the estimated annual gap of USD 2.5 trillion required to achieve the Sustainable Development Goals (SDG) globally; gaps considered beyond the capability of public financing (World Bank and International Monetary Fund, 2015). The quest for improving human wellbeing is now being re-framed around the notion of ‘unlocking the transformative potential’ of the private sector, and bilateral and multilateral organisations are increasingly expected to devote public funds to support that process (United Nations, 2015). But beyond the hyperbole of ‘innovation’ and ‘leverage’, ‘disruption’ and ‘partnerships’, what are the structural features that enable this shift in roles and responsibilities? What institutions and instruments are facilitating it, and what do we know of its consequences?

In this article we explore such questions through an examination of current trends in the financing and organisation of healthcare that situates these within a trajectory of capital formation – specifically the active attempts by state and non-state actors to accelerate and deepen financialization, creating new markets and opportunities for accumulation in the name of ‘development’ (Mawdsley et al., 2018). Health of populations is considered a prerequisite for sustainable development, and USD 371 billion annually is estimated as necessary to achieve targets for SDG3 alone, to ‘ensure healthy lives and promote wellbeing’ (Stenberg et al., 2017). While the aspirations set out in the targets for Goal 3 require many promotion and prevention actions in spheres well beyond healthcare, it is healthcare industries that are experiencing considerable growth (Deloitte, 2019) as global per capita spending on health increases 50% by 2030 with much of the growth concentrated in middle-income countries (Dieleman et al., 2017).

It is within this scenario, and amidst a slowing in the growth of development assistance for health (Dieleman et al., 2017), that we are seeing a shift towards using public funds to facilitate private investment in healthcare companies through equity investments and loans. Up until 2006, just USD 0.4 billion was committed by bilateral and multilateral development finance institutions to private healthcare providers in the form of equity investments and loans. This rose to USD 1.9 billion for the period 2007 to 2015. Almost as much again (an estimated USD 1.7 billion) was committed over 2016 and 2017 alone (Hunter and Marriott, 2018).

We will argue that an examination of the interaction between healthcare and a financialization-development nexus helps us to distinguish the distinctive nature of the latest emerging phase of health system change – that of the transformation of healthcare into saleable and tradeable assets for global investors. For our analysis we draw on policy documents, annual reports, online databases and media sources obtained through a ‘snowballing’ approach, via searches of organisation websites and internet searches using Google. The internet searches used as keywords the names of specific investors and investment projects which were identified from organisation websites and from results of initial online searches that combined ‘health’ with terms such as ‘development financing’, ‘innovative financing’, ‘private capital’, ‘equity investment’, ‘private finance initiative’ and ‘impact bond’. We identify historical antecedents in the commercialization of healthcare provision, sketch out organisations and instruments that are facilitating the entry of private capital into healthcare, and consider its promotional apparatus and how it sits within a particular, functionalist, interpretation of the ambition of universal health coverage. We question the emergent discourse that private investment is the preferred and necessary route to improve health, and highlight population health and equity concerns. The paper concludes with a reflection on potential sites of critique and resistance towards financialization, and areas for further study.

FINANCIALIZATION AND DEVELOPMENT

Financialization in its broadest sense is the ‘increasing role of financial motives, financial markets, financial actors and financial institutions in the operation of the domestic and international economies’ (Epstein, 2005: 3). Financialization creates new patterns of capital accumulation (Fine, 2012; Krippner, 2005) and shapes social institutions and subjectivities (G. F. Davis and Kim, 2015; van der Zwan, 2014), leading to new forms of social regulation (Storm, 2018), and resistance (G. F. Davis and Kim, 2015).

The financialization-development nexus has come under scrutiny by critical social science researchers in the last few years (Mawdsley, 2016). These have pointed to a dissociation of financial returns from the productive economy (Fine, 2012), the cannibalization of the latter to serve the interests of finance (Storm, 2018), and the elevation of shareholder concerns over and above other issues such as social impact. Work on the financialization of food production associated with land-grabbing (Brooks, 2016; Clapp and Isakson, 2018) shows how in linking

the productive economy to the ebbs and flows of finance capital, basic needs like food are subjected to instability while entire sectors and regions are subordinated to the needs of financial markets. Commercially motivated actors may symbolically construct these sectors and regions as sites for investment (Fourcade, 2013; Mawdsley, 2016), but this discourse obfuscates the underlying dependency relationships, imperialism and geographically uneven development that are reproduced through investment and value creation processes (Bortz and Kaltenbrunner, 2018; Pike and Pollard, 2009; Rankin, 2013).

Financialization is enacted through technologies that both individualize and collateralize new areas of life. This is demonstrated powerfully by the ways in which a global push towards ‘financial inclusion’ has manifested in the rapid expansion of credit and other financial services (Mader, 2018). Loan-based technologies such as microfinance have opened up new opportunities for rent-seeking from the poor (Mader, 2014) while promoting indebtedness through individualized, racialized and gendered representations of entrepreneurship in the global South (Rankin, 2013; Soederberg, 2013). The individualized risks for engagement with finance can then be bundled together as asset-backed securities for trading in global financial markets (Lavinias, 2018).

As observed by Fine (2012), it is not merely the expansion and proliferation of financial markets over the last 30 years that has been so striking but also the penetration of such financing into a widening range of social reproduction including housing, pensions and health. A recent *Development and Change* Forum Debate on financialization (Storm, 2018) explored a number of important aspects of this penetration and its consequences in social protection and personal finance. We aim to add to this with a close analysis of the healthcare sector.

Most of the considerable ‘global health’ literature to date has been uncritical but a small critical body of work expresses concerns about volatility, amorality and opacity of private investment into global health (Stein and Sridhar, 2018), health-related bonds issued by GAVI, The Vaccine Alliance’s International Finance Facility for Immunisation (Mitchell and Sparke, 2016) and the World Bank’s Pandemic Emergency Facility (Erikson, 2015b). Erikson’s (2015a) analysis of the Bill and Melinda Gates Foundation’s Global Health Investment Fund for pharmaceuticals is an important example of investment fund scrutiny.

These scholars point to a neglect of structural drivers for poor health – the limitations and inequities of existing health systems and global pharmaceutical markets and intellectual

property regimes – and the bypassing of domestic governments and regulatory regimes for pharmaceuticals (Erikson, 2015b). Relatively little research has been done so far on the practicalities of financialization in healthcare provision. Bayliss (2016) and Eren Vural (2017) have analysed processes, actors and sectoral effects in England and Turkey, respectively, demonstrating the value of detailed national analysis. They show deepening inequities, spiralling costs and market concentration. Here we situate those analyses within global trends for capital formation, highlighting the intersections with development finance.

THE GROUNDWORK OF COMMERCIALIZATION IN HEALTHCARE

The justification for promotion of private investment in social sectors has been fuelled by gaps in adequate resourcing of unified public systems. Healthcare is no exception. A lack of comprehensive healthcare infrastructure and inadequate numbers of healthcare workers has meant that physical access to healthcare has been inadequate in many countries and that technical quality has often been poor (Evans and Pablos-Méndez, 2016).

The expansion of private financial capital in the healthcare sector was also made possible by proactive policies for commercialization. Prior to the 1993 intervention by the World Bank report on *Investing in Health* (World Bank, 1993), healthcare in many settings was delivered by a mix of government providers, a non-governmental not-for-profit (often faith-based) sector, or independent private practitioners and informal solo or family-based practitioners. There were relatively few commercial opportunities for larger formal for-profit organisations until reforms placing an ever-growing emphasis on market creation and cash income (Mackintosh and Koivusalo, 2005). The early stages of the process were marked by moratoria on expansion of public healthcare provision, the contracting out of ancillary services in public hospitals, and by introduction of user fee systems. Fees for healthcare became institutionalized and contributed to households' descent into, and reproduction of, poverty (Krishna, 2010; McIntyre et al., 2006; Storeng et al., 2010), as well as human rights abuses such as forced detention in hospital for non-payment of bills (Yates et al., 2017).

At the time that *Investing in Health* was published the reach of formal, for-profit health service provision had typically been limited to high-income groups (Bloom et al., 2013), but within a decade the presence of private capital had expanded across global health governance, financing and provision (O'Laughlin, 2016), under the rubric of 'public-private partnerships' (Richter, 2004), allowing access to many new loci for profit making. The Millennium

Development Goal era became characterized by ‘public-private partnerships’ across the health sector, encompassing corporate involvement in global public decision-making as part of corporate responsibility initiatives, and the contracting of private organisations to deliver public services (Richter, 2004). For more than a decade the partnership euphemism was employed to legitimise private profit in sectors that have substantial government presence (Richter, 2004; Standing, 2010), and invite transnational capital to influence global public policies (Richter, 2003).

As recent work in this journal has demonstrated, a phase of corporate-oriented healthcare reforms transformed healthcare systems into profitable zones for global capital (Bayliss, 2016; O’Laughlin, 2016; Qadeer and Baru, 2016). For three decades the ‘common-sense’ prevalent amongst much of the global health and development communities was that healthcare commercialization and the application of business methods was both inevitable and more efficient (Mackintosh and Koivusalo, 2005). Within healthcare organisations this perception was supported by the expansion of managerial and finance expertise (Mulligan, 2016). The latest phase has extended these assumptions to include the greater use of private financial capital to expand healthcare infrastructure. Indeed loans with interest for this type of activity are being portrayed as morally superior to development aid ‘handouts’ on the grounds that that the latter address symptoms but not drivers of poverty (House of Commons International Development Committee, 2015).

Private healthcare investments – by development finance institutions and others – have so far predominantly been made in large middle-income countries where the state has liberalized its regimes to allow private activity. For example private healthcare companies burgeoned in India after the federal government lifted national restrictions on foreign direct investment in hospitals in 2000, while the loosening of restrictions on foreign ownership of hospitals in China during the 12th and 13th five-year plan periods offers similar in-roads. In Turkey, a Health Transformation Plan launched in 2003 introduced a purchaser-provider split and mechanisms for public contracting of private providers, enabling that sector to grow and consolidate (Eren Vural, 2017; Yilmaz, 2017).

‘PARTNERSHIP CAPITAL’ AND THE INSTITUTIONAL ARRANGEMENTS FOR HEALTHCARE FINANCIALIZATION

The new patterns of capital accumulation are situated in institutional trajectories that have permitted, and delivered, ever-deepening penetration of private finance. This is not particular to healthcare. Ouma (2016) makes a similar case in highlighting the policies and practices that permit and legitimize agri-finance capital formation, and its limited expansion beyond regions that have well-established agriculture markets. The relationship between development aid and financialization is important to an understanding of these contemporary changes as aid is used to transform new sectors and regions into investor-friendly asset classes and to de-risk opportunities for private investment in those asset classes; an approach that sees private enterprise as the primary means to achieve economic growth (Mawdsley et al., 2018). Development organisations provide technical assistance for the creation of private investment projects such as private finance initiatives (Bayliss and Van Waeyenberge, 2017), and offer co-investments, loans and guarantees to de-risk investments. Development-themed bonds are perhaps the most significant emerging mechanism for using aid to draw in private investment, with new modalities including catastrophe bonds (Johnson, 2013) and impact bonds (Mawdsley, 2016).

The World Bank's private equity investment arm, the International Finance Corporation (IFC), occupies a central role in this process, much as the World Bank has led the private turn in development financing generally. Between 1998 and 2013 the IFC committed USD 1.9 billion in the health sector, including commitments for diagnostic chains, health insurers, information technology and medical education (IFC, 2013b). Its health and education commitments (grouped together in IFC annual reports as 'consumer and social services') had increased from 2 per cent of its overall investment portfolio in 2007, to 8 per cent in 2015 (IFC, 2007, 2016). The IFC's reports *Business of Health in Africa* (2008) and *Landscape of Inclusive Business Models of Healthcare in India* (2014) championed private financing to expand corporate healthcare chains, and the organisation has facilitated private finance initiatives for healthcare infrastructure (IFC, 2013a). Companies in receipt of IFC investments had 142 million healthcare users by 2017, and the IFC aimed to increase this eight-fold by 2030 (IFC, 2017c). A recent article by a principal equity specialist at the IFC noted health to be one of their best performing sectors in terms of returns on investment (Mirza, 2018).

Other multilateral development banks have made investments on a smaller scale, as have government-owned institutions. The former include the European Bank for Reconstruction and Development (EBRD), European Investment Bank and African Development Bank,

while the latter include US Overseas Private Investment Corporation (OPIC), France's Société de Promotion et de Participation pour la Coopération Economique (Proparco), Germany's Deutsche Investitions- und Entwicklungsgesellschaft (DEG) and UK's CDC Group.¹

The investments in healthcare companies made by development finance institutions can be understood as part of their extended role to 'escort' private finance into development (Carroll and Jarvis, 2014). While promoting private capital flows as part of development aid activities is not new, it has become much more central in the era of SDGs (Van Waeyenberge, 2015). The 2015 Addis Ababa Agenda on financing for development, for example, emphasized the need to use public funds to support and expand privately financed and owned infrastructure (United Nations, 2015). Others have preferred to refer to this processes as a 'leveraging' of the private sector (World Bank and International Monetary Fund, 2015) or a 'catalysis' process (IFC, 2016).

Public and private actors of various stripes have pushed for these moves, creating alliances of multinational organisations, national governments and owners of private capital; operating as a single epistemic community (Yilmaz, 2017). Lefebvre (2010) points to the collaborative efforts to deregulate healthcare investment in India that brought together the World Bank, national and state governments, domestic banks, and industry representatives, including the Confederation of Indian Industries and the physician-owners of hospital chains themselves. In Turkey, the Justice and Development Party's Health Transformation Programme, supported by the World Bank, appealed simultaneously to the urban poor and private hospital owners by expanding public health insurance to allow purchasing of services from private healthcare providers (Yilmaz, 2017). In so doing it stimulated rapid expansion in investment and capacity in private healthcare provision, and subsequent market concentration (Eren Vural, 2017). More recently, the national government's programme to construct 25 'health campuses' using private finance initiatives (lenders include EBRD, IFC, OPIC and a suite of private organisations) speaks less to the commercial interests of private healthcare providers and more to those of investment, real estate, construction and medical technology industries.

Another alliance, the steering committee for the IFC's *Business of Health in Africa* report, comprised the Gates Foundation, a former Minister of Health in Nigeria and the founder of

¹ CDC Group was originally named the Colonial Development Corporation, which was then changed to the Commonwealth Development Corporation. The organisation is now known simply as CDC Group.

South Africa-based healthcare multinational, Netcare. The Gates Foundation is a private actor with considerable global influence that is frequently to be found supporting such initiatives; it part-funded the IFC report, has made equity investments in Africa Health Systems Management's Investment Fund for Health in Africa, supported expansion of corporate-led development (McGoey, 2012) and has taken a lead role in the Global Health Investment Fund (Erikson, 2015a). Netcare is lead partner for a consortium awarded an IFC-brokered private finance initiative contract with the Lesotho government for the construction and management of the Queen Mamohato Memorial Hospital; the project attracted worldwide attention for locking the government into a contract with high costs (Oxfam, 2014).

The emergence of wealthy owners of capital looking to expand their influence as 'development partners' is revealing of the opportunities afforded by development financing. Abraaj Capital was briefly a leading fund manager and investor in middle-income country healthcare sectors (Hunter and Marriott, 2018) before foundering on allegations of misuse over its USD 1 billion Growth Markets Health Fund (S. Clark et al., 2018), Abraaj's founder, Arif Naqvi had claimed status as a 'thought leader' by championing the concept of 'partnership capital' – in the form of public and multilateral loan guarantees and risk mitigation for equity companies – as a solution for many of the world's problems including climate change and droughts (Naqvi, 2016). Such claims seem at odds with Abraaj's investments in oil companies such as Kuwait Energy, Byco and PetroTiger, but nonetheless Naqvi joined the United Nations Global Compact as a Board Member. Parts of Abraaj's Growth Markets Health Fund portfolio have since been assimilated by TPG Capital's Rise Fund (Kalesh and Shah, 2018), founded in 2016 by TPG's Bill McGlashan, along with former President of eBay Jeff Skoll, and rock star venture capitalist Bono. In a sign of deepening ties between these private investors and development organisations, IFC and CDC Group recently joined with TPG to launch an Investors for Health initiative promoting private investment in the health sector.

The association of development financing with profit reflects a longer trend of reciprocal benefits in the aid sector that is reflected in the institutions of bilateral/multilateral aid (Sogge, 2002) corporate social responsibility (Herrick, 2009) and philanthropy (McGoey, 2012). What seems to have changed in the current iteration is the acceptance of an argument that private profit and self-interest are somehow *necessary* for development (McGoey, 2012). Naqvi's 'partnership capital' reflected this shift towards overt profit-making for ostensibly philanthropic work.

NEW ASSET CLASSES FOR HEALTHCARE FINANCIALIZATION

‘Investing in health’ means creating opportunities for profitable investments in the health sector (Qadeer and Baru, 2016). Privately financed projects in the healthcare sector to date have sought to expand existing healthcare facilities or construct new ones, and the facilities either pass to public ownership as in ‘private finance initiatives’, possibly with contracted private sector management, or remain in private ownership. Healthcare financialization represents a new phase of capital formation that builds on, but is distinctive from, previous rounds of privatization and neoliberal healthcare reform and this is manifested in the creation of new asset classes. In this section we highlight three instruments that perform this ‘mundane work’ of financialization (Mawdsley, 2016), transforming population ill-health into zones for investment and creating saleable commodities that can be traded by domestic and transnational private capital: private healthcare companies, private finance initiatives for healthcare infrastructure, and impact bonds.

Privately owned chains of hospitals and clinics receive loans and investments to serve their expansion within middle-income countries or relatively wealthy enclaves in low-income countries. They generally follow one of two business models. The first model is characterized by high user fees and aims to support high-end healthcare consumption by aspiring and wealthier segments of the domestic and global population, and to feed into development of a private insurance market. The second focuses on the ‘bottom of the pyramid’; a concept that emerged in the business world during the 2000s as model for generating revenue by selling products and services to poorer groups in society (Prahalad, 2004). In healthcare, ‘bottom of the pyramid’ models are based on Fordist high-throughput approaches that minimize costs and maximize economies of scale (IFC, 2013c) and that look to a future of government subsidies to cover costed packages of basic care for poorer groups who cannot afford their fees.

Private finance initiatives have been used to backload the construction costs for public healthcare facilities in the global North since the 1990s (McKee et al., 2006), and are introduced on the premise that they provide vital healthcare infrastructure and may in some cases offer predictability in payments (Hellowell, 2016). The high overall costs of these arrangements compared to government borrowing has led to increasing criticism within and beyond the healthcare sector in those settings, as discussed in a later section, however a

global South revival of the private finance initiative model is being championed by the IFC (Bayliss and Van Waeyenberge, 2017).

Impact bonds are a nascent asset class in the healthcare sector, with investors providing up-front financing that is returned by outcome funders (usually governmental and philanthropic organisations) based on performance. Examples from low- and middle-income countries include projects to build International Committee of the Red Cross centres for physical rehabilitation in Congo, Mali and Nigeria, and a quality improvement programme for maternity services in private hospitals in India (Social Finance, 2018). A recently announced Cameroon Cataract Performance Bond attracted USD 2 million for the construction of a high-throughput eye care facility in Cameroon, although negotiations to convince OPIC to become the lead investor led to a bond agreement that appears to absolve OPIC of almost any financial risk as the entire investment principal will be returned plus 4 per cent interest even in the event of project implementers not meeting targets, with an interest rate of 8 per cent if targets are met (Oroxom et al., 2018).

Investment platforms and fund managers occupy a central role in the development of healthcare asset classes. They enable investors to pool resources and spread risk, transform fixed infrastructure into investor-friendly assets and mediate relationships across regulatory regimes (Searle, 2018). Alliances of state and non-state actors including the IFC and Gates Foundation have been pivotal in developing intermediary investment funds, for example those focused on health sectors in African countries (Marriott and Hamer, 2014), and follow on from more than a decade of ‘emerging market’ investment funds that occupy practical and performative roles in financialization (Fourcade, 2013). The use of intermediary funds, many of which are registered in tax havens such as Mauritius and the Cayman Islands, provides additional opportunities for rent extraction by companies that manage and audit the funds and associated legal work, with little transparency and accountability (Hunter and Marriott, 2018)

The framing of healthcare infrastructure as an asset class reflects wider attempts to find commercial value in social sectors. Infrastructure projects are structured into packages with the most lucrative offered to private investors and for global trading. Smaller projects may be bundled together to attract larger commercial investors which, as Bayliss and Van Waeyenberge (2017) note, is driving a standardization of private finance initiative processes, regardless of the sector involved and implications for service provision. There are similar hopes amongst industry representatives that impact bonds will eventually be traded in bond

markets, but as Mawdsley (2016) notes the complexity and cost of their novel commodification system which has hampered more widespread use. Meanwhile the expansion of universal health coverage insurance schemes provides mechanisms for public subsidy of private profit-seeking activity and functions as a state-backed security for rent extraction by finance capital, akin to that offered by conditional cash transfers (Lavinias, 2018). Whereas personal credit is secured by social protection policies such as cash transfers that ensure a regular stream of income, hospital debt is secured using state-backed health insurance that ensures steady streams of healthcare users and revenue.

Generating templates and success stories for replication is likely to be key to expanding these asset classes. The announcement in 2010 of the Turkish government's plan to build 25 health campuses using private finance initiatives was soon followed by selection of Istanbul as the venue for the IFC's 2013 biennial Global Private Health Conference, themed *Making Global Connections: Leading Change in Emerging Health Markets*. The Cameroon impact bond project explicitly draws inspiration from the Aravind healthcare chain in India (OPIC, 2017), which has been heavily touted for a decade by development organisations as an inclusive and reproducible commercial model for healthcare provision (IFC, 2014) and which indicates the importance of longer-term marketing efforts in the financialization-development nexus.

RHETORICAL RE-CONSTRUCTION OF INVESTMENT MARKETS

The promotional apparatus that facilitates this new world view about what population health requires, and brings it to governments, is considerable and well-versed. Development finance institutions have worked alongside a range of corporate and non-corporate actors to promote healthcare systems as sites for generating returns on investment. The Big Four financial auditors and Big Three management consultancies produce many reports that highlight market 'opportunities' in healthcare, for example, McKinsey published *Healthcare in China: Entering uncharted waters* in 2012 followed by KPMG's *Commercial Opportunities in the Primary Care Market in China* in 2016. Other reports present stories of successful businesses to encourage investment and liberalization in the sector. Deloitte produced the IFC's 2014 *Landscape of Inclusive Business Models of Healthcare in India* report and KPMG's 2014 global healthcare conference was followed by a report entitled *Staying Power: Success stories in global healthcare*. PricewaterhouseCoopers has sponsored a series of case study

reports on private finance initiatives in the healthcare sector, including a review of projects in Latin America (Llumpo et al., 2015).

Through these activities, healthcare systems in the global South are re-imagined as marketplaces for investors to engage with. It is an activity that development finance institutions have been keen to emphasize and reflects the contemporary development trend in which entire sectors and countries are labelled ‘emerging’ and ‘frontier’ markets to encourage investment (Fourcade, 2013; IFC, 2017a; Mawdsley, 2016). These rhetorical devices enable interested actors to construct a future of prosperity and investment growth (Beckert, 2013; Thrift, 2001) and the value of financial products such as shares in healthcare companies is driven by these imagined futures (G. Clark et al., 2004).

In healthcare, the imagined future driving investment draws explicitly on the growing burden of chronic diseases and the somewhat increased capacity of ‘middle-classes’ to pay for healthcare. People facing a life-time of debilitating diseases are presented as resources to be exploited:

‘There has never been a more exciting time to be an investor in health in emerging markets. Rising incomes in developing countries are propelling rapid growth of demand for health goods and services, while disruptive technologies and innovation is creating new ways of meeting this demand. Meanwhile, the growing prevalence of non-communicable diseases like cancer, heart disease, and diabetes is upending perceptions of the needs for health in developing countries. Developed and developing countries alike are struggling to cope with the high cost of these diseases, in terms of lost lives, lost productivity, infrastructure financing, and the human capital required to treat them.’

IFC Head for Health and Education in the inaugural issue of the organisation’s healthcare newsletter *Private healthcare in emerging markets: an investor’s perspective* (IFC, 2015).

The attractiveness of healthcare to commercial actors is similarly bluntly presented in the business press. A South African fund management company representative quoted in Bloomberg (McClelland, 2016), states: ‘The economics behind AIDS and HIV can be lucrative because treatment requires not only medicines but also nutritional requirements [...] there are opportunities through the value chain from wholesalers all the way to distributors’.

Hospital managers, and an emerging corpus of ‘social entrepreneur’ physicians (Martin, 2014), often play a key role in legitimising these constructions through their active support for investment and the infrastructure expansion that comes with it, sometimes attracting significant personal status and wealth in the process. Founders of hospital chains are described by the business press as ‘visionary’ (IFC, 2011: 6; Kemperman et al., 2016: 392), with frequent mention made to personal Entrepreneur of the Year awards conferred by financial newspapers and the World Economic Forum.

At the same time, individual citizens are invited to organize their daily lives through active individual risk management, and engage with financial markets through purchase of loans and insurance. Like microfinance loans, health insurance packages have been marketed globally as a way to manage the financial risks, in this case the risk of ill-health, with vocal support for expansion of commercial insurance coming from the World Bank and the private investment industry (Averill and Marriott, 2013; Birn et al., 2016). These packages not only provide new flows for revenue extraction by insurance companies and their investors, but also offer protection for existing flows. For example, SKS made its microfinance loans for low-income clients in India conditional on the purchase of an SKS private health insurance product (Banerjee et al., 2014). Financialization has created a new subjectivity: the ‘investing subject’ – the ‘autonomous individual who insures himself against the risks of the life cycle through financial literacy and self-discipline’ (Aitken, 2007: 13, quoted in van der Zwan 2014).

THE CURIOUS BED-FELLOWS OF FINANCIALIZATION AND UNIVERSAL HEALTH COVERAGE

The concept of ‘universal health coverage’ is a recurring theme in the documents that support private finance in the healthcare sector, just as ‘financial inclusion’ features prominently in the extension of financial services to low-income communities (Mader, 2018). In this scenario the right to population health and its array of promotive, preventive, primary and curative services becomes displaced by a much more restricted right to healthcare ‘coverage’ (Birn et al., 2016; O’Laughlin, 2016; Qadeer and Baru, 2016). And so, despite growing knowledge of the social, political and commercial drivers of poor health, the SDG target to achieve universal health coverage by 2030 becomes widely interpreted as necessitating significant expansion in healthcare infrastructure and insurance.

Dominant healthcare financing models in different countries may mediate the impact of financialization, and ‘universal health coverage’ is a broad enough term to incorporate a range of publicly managed financing arrangements but is in practice characterized by concerted efforts to promote models of healthcare financing based on ‘affordable’ user fees and health insurance, and on expansion of privately owned healthcare infrastructure (World Bank, 2016). Mexico’s voluntary health insurance system – Seguro Popular – has been held up as a role model for achieving universal health coverage (Frenk et al., 2019) as it offers to finance basic healthcare services for previously uninsured groups. However, by offering coverage for a more limited set of healthcare services than other insurers, for example excluding services for diabetes-related illness, Seguro Popular reinforces social divisions in an already fragmented healthcare system (Birn et al., 2016).

Until recently, development finance institutions had made the case for equity investments and loans in the healthcare sector on the basis of job creation (Hunter and Murray, 2015), but ‘UHC’ is fast becoming a preferred justification for their activities. The concept was invoked by the IFC in the run up to its 2017 Global Private Health Conference (IFC, 2017b), and by CDC Group (2017). Commercial actors quickly saw the promotional benefits: KPMG has established a Center for Universal Health Coverage; Abraaj cited universal health coverage as necessitating its commercial investments (Abraaj Group, 2017); and technology company Philips employs the concept when promoting its investments and technology packages on development media platform Devex (Devex and Philips, 2017). Such developments indicate that the concept now occupies a central role in justifications for the financialization of healthcare.

The shifting rhetoric around private capital and universal health coverage reflects the arrival of an implementation phase for the SDGs, where aspirational goals are operationalized as policies with time-bound targets and costed financing gaps (Stenberg et al., 2017). Like the Millennium Development Goals before them, there is an impetus for quick gains using technologies that bypass systemic problems such as under-resourced public healthcare systems and for portrayal of these systemic problems as themselves requiring technical intervention (Storeng, 2014), usually incorporating contracts for commercial actors. Private investment in healthcare provision and financing is now presented as the only solution for addressing geographic gaps in healthcare provision, high mortality, and catastrophic out-of-pocket expenditures. As recently noted in a report produced by KPMG and academic researchers on behalf of the World Innovation Summit for Health, achieving universal health

coverage by 2030 'is too ambitious to be achieved without leveraging existing private capacity, investment and innovation' (Roland et al., 2018).

SOCIETAL AND HEALTH EFFECTS OF 'INVESTING IN HEALTH'

Davis and Kim (2015)'s review of the sociological literature makes a key point that financialization not only represents a power shift from industrial corporations to the financial sector but also a shift from social institutions to markets as the dominant organizing principle. While the narrative around healthcare investment seems to imply that investors, entrepreneurial physicians and investing subjects work in the interests of population health and healthcare systems, a private investment-fuelled expansion of these healthcare provision models raises important questions about the decline of healthcare systems as social institutions and the implications for equity. The expansion of privately financed projects is primarily a commercial venture to which population health is a secondary, indeed sometimes a contradictory, consideration. Increased access to diagnostics plus ever more costly treatments have become the principle response to meet an epidemic of chronic illnesses that are fuelled by demographic and epidemiological changes and by the dominance of commercial interests over health concerns in the food, drink, transport, agriculture and manufacturing sectors (Buse et al., 2017; Popkin et al., 2012; Swinburn et al., 2019; World Health Organization, 2015).

The effects in the shorter term include health and financial risks, as well as longer term inequity and social segmentation. An emphasis on value creation for investors encourages outsourcing (G. F. Davis and Kim, 2015) and distorts healthcare provision to maximize profitability, undermining health and increasing the drain on the public purse and depleting family resources. Healthcare professionals in corporately owned hospitals, for example, face overt and implicit incentives to increase revenue (Nundy et al., 2018) which manifest in many settings with over-testing, over-diagnosis and unnecessary treatments (Morgan et al., 2015). Unexpectedly high rates of CT/MRI scans, caesarean section births, hysterectomies and cardiac surgeries appear to be a growing problem in low- and middle-income countries (Brownlee et al., 2017). Unjustified surgical procedures have particularly important negative implications for health, including risk of subsequent infection, cardiovascular problems and death.

The financial burden of healthcare can either lead to additional costs for governments who try to provide insurance cover, or can push service users into outright poverty. Each year an estimated 100 million people are forced below the USD 1.90-a-day poverty line by out-of-pocket healthcare expenditure (World Health Organization and International Bank for Reconstruction and Development, 2017). In countries such as Bangladesh and India large out-of-pocket healthcare expenditures are disproportionately due to costs of care in the private sector (Kanjilal et al., 2008; Rahman et al., 2013), and yet many of the companies expanding with support from development finance institutions, including the ‘base-of-the-pyramid’ models, are corporate enterprises offering fee-based care that must be purchased by out-of-pocket payments or private health insurance.

Perhaps the most significant meso-level change taking place now is the drift towards acceptance and normalization of healthcare markets, commercial imperatives and of segmented healthcare systems. Population groups, geographic areas, and policy areas such as public health that are deemed unprofitable can be neglected unless further public subsidies can be obtained in the form of insurance programmes or ‘public-private partnerships’ (Bayliss and Van Waeyenberge, 2017). One motivator for governments to pursue the infrastructure that will service segmented healthcare systems is engagement with the global healthcare economy and related service sectors. Turkey’s ‘health campus’ projects appear to be targeted as much at competing for international medical travel as at meeting the needs of domestic communities (Rosca, 2016). Similar state government initiatives in India have incentivised large healthcare complexes (‘medicities’), some located in special economic zones, to attract healthcare tourists (Murray et al., 2016).

Of particular concern is the way in which the segmented systems that are being expanded reject single risk pools for healthcare and the redistribution of wealth needed for social solidarity and equitable healthcare access (Mulligan, 2016), undermining universalism in healthcare (Birn et al., 2016). Recent research demonstrates the role of finance in shaping pharmaceutical and private health insurance industries and their decision-making. Burlage and Anderson have described how private investment in pharmaceutical industries is associated with a business strategy that eschews research and development in favour of acquiring other companies (and their patents) and gouging prices (Burlage and Anderson, 2018). Mulligan’s anthropological study of a health insurance company in Puerto Rico shows how private health insurance is characterized by shareholder value maximization strategies that are introduced and driven by finance experts in the insurance companies (Mulligan,

2016). Companies hide and offload costs while de-pooling and individualising risk and responsibility through segmented (risk-adjusted) pricing for premiums. The nature of effects are industry-specific, so similar pressures in the care sector have manifested in the erosion of wages and employment conditions for frontline workers who have limited access to collective organisation for resistance (Horton, 2017).

Segmented national healthcare systems are highly inequitable, and Chile provides an example of how, despite achieving ‘coverage’ on healthcare indicators, such system arrangements fail the poorer sections of society and terminally undermines the quality of public provision. The Chilean military government of the 1970s was one of the first to seek to reduce public spending and encourage market solutions by actively creating two parallel and separately funded ‘sub-systems’ of healthcare provision in which the private system primarily served the needs of the wealthy and healthy males with salaries and incentivised private insurance plans. The over-stretched public system was left to deal with the remaining majority of the population, and with the complex problems of poverty and chronic disease, while struggling to retain the specialist doctors that they train given the insufficient investment, long waiting lists and heavy workloads. The private sector has been quick to exploit the new market opportunities. Private hospital infrastructure has multiplied in urban areas as public funds are re-routed to purchase (with user co-payments) its packages of care in selected profitable areas with high bed occupancy and rapid throughput such as maternity care. It is a cycle that fuels healthcare industry expansion, perpetuates specialist flight, deprives the public sector further of funds, and jeopardises the quality of care in rural and poor urban areas (Murray and Elston, 2005; Rotarou and Sakellariou, 2017; Siebert, 2015). Countries now pursuing private investment-fuelled infrastructure expansion are likely to experience similar trajectories.

Meanwhile trends towards greater concentration of ownership in the healthcare provision sector suggest a growing public reliance on the resources of a small number of corporately owned chains that are driven by shareholder concern with dividends and company value, with serious long-term implications for costs and regulation. Healthcare companies are pursuing acquisitions and fast rates of growth in the number of facilities to increase company value. In Turkey this has led to rapid expansion and concentration in the private healthcare sector (Eren Vural, 2017), and other commentators have pointed to similar trends for concentration in India (Chakravarthi et al., 2017) and South Africa (Munyai, 2018) – countries that have been the focus of ‘leveraging’ efforts by development finance institutions. The search for new markets has also encouraged transnational activity and middle-income countries in Eastern

and Western Africa are attracting particular attention (Mohandas, 2016). Little attention is being paid to the ways in which expansion and consolidation by these companies is ‘locking in’ particular models for healthcare provision and financing. The influence of these chains in domestic politics makes it a trend that is difficult to reverse (Dreze and Sen, 2013: Ch. 6).

The use of private finance initiatives to expand public healthcare infrastructure offers little consolation given their relative high cost to the public purse compared to other forms of financing (Bayliss and Van Waeyenberge, 2017), and long-term escalation of costs has been documented in a rapidly growing body of literature from the global North (Pollock, 2005; Whiteside, 2015) and the global South (Webster, 2015). Increasingly public organisations in those countries are trying to extricate themselves from private finance initiatives, with mixed success (J. Davis et al., 2015), and a global coalition of non-governmental organisations has called on the World Bank and other development organisations to stop promoting such models (Eurodad, 2017).

CONCLUDING COMMENTS

Other scholars have interrogated the recent history of capital relations in healthcare (for example O’Laughlin, 2016). Our analysis advances this by charting the contours of an emerging financialized phase. In this article we offer a de-construction of financialization in healthcare that enables us to see current developments situated within wider patterns of capital formation. We highlight the antecedents, institutions, instruments and ideas that facilitate the process and we argue that the transformation of healthcare into a set of saleable and tradeable assets has built on four decades of healthcare commercialization that has deregulated activities to enable profitable investment and provision. This latest phase is characterized by a ‘common-sense’ policy position amongst many governments and bilateral and multilateral development agencies that enormous volumes of private financial capital are necessary for promoting development in the healthcare sphere, and by the development of new asset classes. Closer scrutiny reveals alliances of domestic and transnational private capital using highly selective representations of ‘development’ to favour healthcare models that permit the extraction of revenue from situations of vulnerability.

As a consequence healthcare markets are being formed with little regard for effects on health and equity. Corporate provision of healthcare, for example, is promoted as offering high quality and affordable care as either a transitional or permanent contributor to achievement of

universal health coverage. Yet there are important reasons to be sceptical about this narrative and the effects of a corporate-oriented transformation in healthcare systems. The proposed infrastructure expansion and the focus on profitable treatment of illnesses or related diagnostic services has inherent problems that stem from the need to generate revenue or capital growth for the benefit of investors. Similarly, problems arise from the roll-out of insurance models that rely on unbundling of risk, or that aim to generate profit from government commitments to provide in-patient care. Many provide regular income for the private healthcare sector and aid the penetration of the insurance industry in the health sector, and they contribute to locking in models of healthcare that undermine social solidarity and redistribution of wealth, and that divert public funds from more progressive health promotion activities such as public health interventions.

The euphoria of the buzz, and buzzwords, of financialization have begun to permeate some potential sites where critique and resistance might have been anticipated, and private investment in healthcare is fast-becoming an unquestioned policy in global health. Organisers of a leading biennial global health systems conference – the Global Symposium on Health Systems Research – chose to set up the differing views on private sector engagement for provision and financing as a conflict between ‘pragmatism’ and ‘polemic’, thus leaving little invitation to critical analyses (Health Systems Global, 2018). Public health and higher education institutions, themselves now subject to the same financial imperatives which circulate in healthcare provision, have embraced new opportunities to be contracted by investor groups to conduct research that will support the fine-tuning of investment activities and bolster their gravitas and feel-good image. The commissioning of a prestigious academic research group by CDC Group to help produce an evaluation template for their healthcare investments reflects a recent trend for public health academics to conduct market-related research for spin-off third-party ‘initiatives’ funded by commercial interests that might otherwise be performed by commercial consultancy agencies.

However organized resistance has also emerged, in particular from civil society alliances. Analyses, lobbying and campaigns by the People’s Health Movement (2017), the global trade union federation Public Services International (Lethbridge, 2016) and Oxfam (Averill and Marriott, 2013; Oxfam, 2014) figure among these. Such alliances also connect to networks of non-governmental organisations and academics concerned with a private turn in development finance (Eurodad, 2017; Gabor et al., 2018). In some settings healthcare professional associations have attempted to stall reforms that permit commercialization and financial

capital-fuelled private healthcare expansions (Iriart, 2005; Yilmaz, 2017), in others, groups of professionals are organising through national and international networks such as the Community of Practitioners on Accountability and Social Action in Health (COPASAH). In a few cases in Latin America, such as Bolivia and El Salvador, national governments have also acted to overcome industry opposition to introduce legislation that rolls back commercialization and expands healthcare entitlements (People's Health Movement et al., 2014).

Inspiration for further scholarly contribution can be drawn from the burgeoning body of social science studies on financialization (Bayliss et al., 2016; G. F. Davis and Kim, 2015; Storm, 2018), and we see opportunities for interdisciplinary research to generate critical insights through detailed analysis of processes for identifying investment targets and engaging investors. Processes of financialization have permeated social reproduction worldwide, driving public policy and providing lucrative returns for finance capital. It is clear that the current shift towards private finance in development risks diverting attention away from core principles of equity and social justice, away from the possibilities for creating de-commodified zones in social reproduction, and towards profitable projects and greater inequality. Research that further examines the actors, processes and effects of the financialization-development nexus will be key to unravelling the pervasiveness of the narrative of private finance solutions to public problems.

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