



Spotlight on financial justice Health

Making health a global bankable project



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Front cover image: Clinic in Carrefour slum in Port au Prince where blood tests and vaccinations are administered. **Picture credit:** Christian Aid / Elaine Duigenan.



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Who we are

Citizens for Financial Justice

Informing, connecting and empowering citizens to act together to make the global finance system work better for everyone.

We are a diverse group of European partners – from local grassroots groups to large international organizations. Together, we aim to inform and connect citizens to act together to make the global financial system work better for everyone.

We are funded by the European Union and aim to support the implementation of the Sustainable Development Goals (SDGs) by mobilizing EU citizens to support effective financing for development (FfD).

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You can view the full report on the Citizens for Financial Justice website:
citizensforfinancialjustice.org

Executive summary

This summary relates to the full version of the report *Spotlight on financial justice: understanding global inequalities to overcome financial injustice*.

Rising inequalities between the global North and South, the economically privileged and the marginalized, between different genders and racial identities, have been historically reproduced and intensified across generations, and are defining features of our times. For instance, while global challenges such as climate change and environmental degradation undoubtedly affect all of us as humans living on Earth, they certainly do not affect us all equally. Differences in geographic location, economic status, gender, age, all come into play if we look at the groups who are systematically suffering from climate change's harsh consequences.

This is because the current rules of our global economy reproduce a vicious circle of inequality: growing economic inequality and wealth concentration increase political inequality by expanding the ability of corporate and financial elites to influence policy-making and protect their wealth and privileges. Higher levels of inequalities are then passed on to the next generations, culminating in long-term disparities and unfairness felt by marginalized groups.¹

After the 2008 global financial crisis hit, the governance structures and economic (de)regulations that got us there, especially the unchecked expansion of the financial sector over the rest of the economy or 'financialization', finally raised enough red flags. While major banks were bailed out by taxpayer's money, states neglected their basic human rights obligations by turning to austerity measures, creating pervasive impacts on people's lives around the globe. Consequences include reducing communities' access to common natural resources² and restricting the delivery of basic public services such as healthcare and housing to the most disadvantaged groups.³

In recent years, a significant increase of disparities within and between countries has finally put inequalities under the spotlight within international

development debates.⁴ The 2030 Agenda recognized addressing their multiple facets (economic, political, social) as one of its Sustainable Development Goals (SDGs), signalling the international community's commitment to reducing inequalities.

To take advantage of this momentum, understanding the main contemporary drivers of inequalities and finding common strategies to address them are necessary steps towards systemic socio-economic transformation and social justice. Looking at our current challenges through the lens of inequalities offers then a remarkable transformational potential: tackling inequalities in their multidimensional character – social, political, economic, spatial and intergenerational – can become a sort of guiding star in a complex world, an overarching goal to advance sustainable development and address the root causes of marginalization. As part of this effort, this report tackles the inequalities question by looking at one of its main current drivers, the financialization of our global economy, as well as at its counterpart, financial justice.

Through five thematic chapters – 1) food and land, 2) health, 3) women's rights, 4) housing and 5) infrastructure, the report shows that rising inequalities, and the overexpansion of the finance industry as one of its key contemporary drivers, have been created and reproduced by skewed and unfair rules of the game. There is therefore an urgent need for peoples' movements to converge around a common agenda for taking back our economies, reclaiming public services, and protecting our common natural resources. Through this report it becomes evident that local level resistance to financial actors' penetration is extremely important, but that confronting the drivers of inequality which are now global, such as financialization, requires concerted efforts at higher levels of policy-making as well. Four main pillars for action are proposed:

1 https://www.2030spotlight.org/en/book/1730/chapter/1-increasing-concentration-wealth-and-economic-power-obstacle-sustainable#footnote10_utsqgho

2 See case of Brazil, Chapter 1, Spotlight on financial justice, 2019, <http://caid.org.uk/spotlight>

3 See case of Greece, Chapter 2, Spotlight on financial justice, 2019, <http://caid.org.uk/spotlight>

4 <https://sustainabledevelopment.un.org/sdg10>

- **Promote shared understanding and ongoing questioning of the dynamics of financialization:**

It is essential to raise people's awareness around the very real impacts of financialization on their lives and to provide fresh analytical tools to question current dynamics. Challenging the inequalities problem and how the multiplicity and expansion of financial actors and services is contributing to the problem can avoid unintended complicity, particularly given the insidious and overly covert manner in which these dynamics infiltrate multiple domains of life;

- **Resist ongoing attempts to shift decision-making away from legitimate and democratic policy spaces, often in the name of 'financing opportunities' to advance progress:**

At the local and national levels, supporting social movements' resistance to harmful projects, policies and other interventions backed by global financial actors can create tangible wins and can put a face and shape onto a struggle that can so often feel immaterial and hard to grasp;

- **Reaffirm national sovereignty to re-establish healthy boundaries to financial liberalization and provide critical financing to achieve the Sustainable Development Goals (SDGs):**

The latest global financial crisis has critically exposed the vulnerabilities of a liberalized, privately focused financial system. However, many underlying structural conditions that led to the crisis have been only mildly addressed, if at all. It is therefore essential to re-establish national sovereignty to help prevent the next crisis while providing critical financing for sustainable development. This calls for exploring the potential of national development banks, restoring the management of capital accounts within the standard policy toolkits of governments, and, introduce a system of financial transaction taxes, among other measures;⁵

- **Democratize global economic governance:**

At the global level, social justice and rights-based narratives should be at the heart of the process of reshaping powerful global institutions and reforming global economic governance. Different sectoral struggles should unite under a common agenda, advocating for the reform of existing institutions and the establishment of new ones which are able to regulate the new and fast

evolving financial actors, and can bring finance back into democratic accountability and control. This calls not only for building convergence on existing proposals regarding critical new pillars of a democratized economic governance ecosystem, such as an intergovernmental tax body and sovereign debt workout institution under the aegis of the United Nations, but also for addressing the institutional vacuum in regulating financial actors, mostly though not exclusively the asset management industry. Such measures could translate in enhanced transparency, participation, and public oversight of domestic and global tax, fiscal and financial policy-making.

The time is ripe for acknowledging people's struggles to resist the multiple facets of the process of financialization, and for converging strategies to address multiple dimensions of inequality to reach financial justice. The time for financial justice activism is now!

5 K. Singh and S. Prato, "Preventing the next financial crisis while financing sustainable development: Three propositions", *Spotlight Report on Sustainable Development*, 2019, https://www.2030spotlight.org/sites/default/files/spot2019/Spotlight_Innenteil_2019_web_chapter_III_Singh.pdf

Health

Making health a global bankable project

by Nicoletta Dentico, Society for International Development (SID).

“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

Financial institutions and the infrastructures of financial intermediation are the protagonists of today's economic order and have come to play a central role in the health domain. This process of making global health increasingly dependent on financial markets is sometimes described as 'financialization', a trend that is now touted under the banner of sustainable development and the provision of Universal Health Coverage. Yet, it presents a range of critical issues in terms of health governance and organization, corporate sector monopolies and demands for democratic participation, unequal access to healthcare, as well as cultural and political redefinition of the way the universal right to health should be interpreted and pursued.

From Alma Ata to the impact of the 2008 financial crisis on Greek health

The inseparable connection between the right to health and the international economic order mentioned in the Alma Ata Declaration⁶ is a hard lesson that Greek people know too well. Their story, however, has nothing to do with the aspiration to develop an economic system tailored to compensate the wrongs of colonialism and foreign economic domination “in the spirit of social justice”, as the

authors of the Declaration put it. The Greeks have rather paid an unbearable price for the economic disorders of globalization based on privatization and deregulation, particularly the financial crisis that erupted in September 2008 caused by US private banks' loan policies. The first financial crisis to become of planetary scale ever. The overbearing economic adjustment programmes imposed on Greece and other countries by the European Union (EU) and the International Monetary Fund (IMF) when the crisis hit Europe are a stark reminder that the world's biggest creditors are unlikely to care much for social justice, people's rights and national sovereignty when their finances are at stake. One of the biggest problems still today remains in an area that Europeans have long prided themselves: public health.

When Greece defaulted in May 2010, Europe's largest insulin supplier, Novo Nordisk, was the first to declare its decision to stop selling certain types of insulin (17 products) to people in Greece who have type 1 diabetes and need insulin for their very survival (over 50,000 patients). The Danish company rejected the Greek government requirement to cut prices by 25 percent, refusing “to be bullied into price cuts” - this is apparently what happens when corporations are let loose on the world. As compensation, Novo Nordisk offered to make another product available in its generic version, free of charge:⁷ a better option for them than having to jeopardize its dominant position and review the insulin standard price for the whole of Europe; and a striking confirmation of the link between money-making and health, if anyone had any doubts.

In June 2016, a louder bell about the impact of the EU austerity policies on health was sounded by the National Bank of Greece.⁸ Its report provided the statistics to prove the extent of deterioration of Greek health in the years of loan agreements and austerity cuts. Policies were often implemented rapidly, without sufficiently considering potential side effects, when the Greek government was forced to reduce investments and put severe strains on core

6 https://www.who.int/publications/almaata_declaration_en.pdf

7 <https://www.bbc.com/news/10189367>

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

social services, inflaming inequality and undermining community resilience to the crisis. The national health budget alone suffered a contraction of 36 percent between 2009 and 2014: cost sharing for healthcare increased significantly, even for those with insurance, while entitlement restrictions were introduced in relation to childbirth and a number of other essential treatments.⁹ Such a meltdown of the public health system resulted in a 50 percent increase in infant mortality, especially among infants younger than one year; the increase of chronic diseases by 24.2 percent, due to the collapse of the healthcare system and the absence of the needed medical treatments caused by lack of financial means; and in the sharp increase in mental illness among the population due to the economic crisis, from 3.3 percent in 2008 to 12.3 percent in 2013. According to the *British Medical Journal*, the overall suicide rate rose by 35 percent between 2010, and 2012.¹⁰ Greece's prescription for the shock to the healthcare system was state subsidized health insurance, but with the unemployment rate at 27 percent, many remained outside the eligibility criteria.

Financialization and its “weapons of mass destruction”



The shape of our economy and the texture of our lives within it is deeply affected by financial flows and their volatility. This trend is sometimes described as ‘financialization’, which refers to “the increasing role of

financial motives, financial markets, financial actors and financial institutions in the operation of domestic and international economies”.¹¹ Through privatization, deregulation and credit flows, financialization has overseen a large-scale conversion of public wealth into private capital. The 2008 financial crisis only magnified this process, when publicly financed bailouts were adopted to cover the risks taken by private financiers.¹² As a recent publication by the *Transnational Institute* suggests, “public finances amount to more than US \$73 trillion, equivalent to 93 percent of global gross

domestic product, when we include multilaterals, pension and sovereign wealth funds, and central banks”.¹³ This means that the efficient allocation of public capital is one of the most valuable tasks in a global economy, and finance has tremendous potential if we are to address the enormous structural inequality that has become the defining feature of our time.

But we can do much better. The 2008 global financial and economic crisis is an eloquent demonstration that *laissez-faire* does not work. Financial markets left to themselves produced too-big-to fail banks and did not stimulate competition but rather oligopolies and several blows to regulators’ attempts to organize markets in the public interest. The prices of financial assets did not manage to signal the incoming crisis. The profitable speculations that disrupt the economic system and lead to collapse and misery for the millions of people affected - “financial weapons of mass destruction”, as investor Warren Buffet calls them - come with very high payments for societies, as we have seen for Greece, alongside many other countries in the global North and in the global South, following the crisis. They describe the route the world takes when “financial markets, financial institutions and financial élites gain greater influence over economic policy and economic outcomes”.¹⁴ This is what the financialization of the economy is about. A process that ultimately threatens the very funding efforts needed to meet the Sustainable Development Goals (SDGs), and makes us all vulnerable to the frequent crisis cycles that casino capitalism driven by digital high-frequency trading needs to survive.

A healthy business for the financialization of development

The stimulus to private financial capital into the healthcare sector has a historic precedent. It stems from the World Bank’s breakthrough 1993 report *Investing in Health*,¹⁵ which introduced the reforms that placed an ever-increasing importance on generating markets and cash income in the healthcare sector.¹⁶ The inception of the reform’s implementation was

9 http://www.euro.who.int/_data/assets/pdf_file/0007/266380/The-impact-of-the-financial-crisis-on-the-health-system-and-health-in-Greece.pdf.

10 C. Branas, A. Kastanaki, et al., “The impact of economic austerity and prosperity events on suicide in Greece: a 30 year interrupted time- series analysis”, *British Medical Journal*, 2014. Available at: <https://bmjopen.bmj.com/content/5/1/e005619..>

11 G.A. Epstein, “Introduction: Financialization and the World Economy”. In G. A. Epstein, ed., *Financialization and the World Economy*, Cheltenham: Edward Elgar Publishing Ltd, 2006, pp. 3-16.

12 I. Ortiz and M. Cummins, M., “The age of austerity: a review of public expenditures and adjustment measures in 181 countries,”, Working Paper, New York and Geneva, Initiative for Policy Dialogue /South Centre, 24 March 2013. Available at: ssrn.com/abstract=2260771.

13 L. Steinfort and S. Kishimoto, *Public Finance for the Future We Want*, Transnational Institute (TNI) , Amsterdam, June 2019.

14 T. Palley, “Financialization: What it is and Why it Matters,” University of Massachusetts, Amherst Political Economy Research Institute, Working Paper 153, 2007. Available at: <https://ideas.repec.org/p/uma/periwp/wp153.html>.

15 <https://openknowledge.worldbank.org/handle/10986/5976>.

16 M. Mackintosh and M. Koivusalo, *Commercialization of Health Care: Global and Local Dynamics and Policy Response*. Basingstoke: Palgrave Macmillan, 2005.

structured with moratoria on the expansion of healthcare provision, the contracting of ancillary services in hospitals, and the introduction of very controversial users' fee schemes. When the report was published, the model of formal, for-profit healthcare provision had basically been limited to high-income countries. It took less than a decade for the presence of private capital to flood across global health governance, financing and provision of healthcare, under the seductive disguise of public - private partnerships (PPPs): principled pragmatism to replace institutional arrangements.¹⁷

The Millennium Development Goals (MDGs) have been the testing ground for the public-private partnership model, through the fight against poverty and pandemic diseases in developing countries, particularly. But this agenda has been further developed to aim at the overall health sector, and to institutionalize the presence of corporate actors in the contentious arena of public decision-making on global health,¹⁸ including in the design of the SDGs.

elements of a service traditionally provided by the state, such as hospitals, schools, transport and sanitation, among others. Companies get repaid either through fees contributed by users, or by payments from the state. Concessions are classic versions of PPPs, in which private sector players agree to construct or operate a specific system (water, healthcare, electricity, etc.) in return for a monopoly awarded by the state, allowing them to cover costs and generate profits by charging users. The primary reason why governments pursue PPPs is their need to bypass the neoliberal cost-containment measures constraining public borrowing. The reality is that, in most cases, PPPs are the costliest financing strategy for the public sector, particularly in the long run. Moreover, they foster inequality, because they favour those who are already wealthy (asset and capital holders), while often extracting cash from the disadvantaged.¹⁹

What are public-private partnerships?

Public-private partnerships (PPPs) are seen as a logical response to the structural changes in the state-market relations that has occurred since the beginning of economic and financial globalization, with the rolling back of state responsibilities and the massive growth of corporate influence. They embody a major governance shift in the provision of public services: from the institutional setup based on formal structures and traceable lines of responsibilities to functional initiatives or contracts based on voluntary approaches, and institutional hybridization.

PPPs may vary in genesis and objectives. Altogether, they are long-term contracts between governments and private companies, underwritten by government guarantees, under which companies finance, build and operate

Re-imagining healthcare systems as marketplaces for investors



The health of populations is a preliminary condition for sustainable development but tremendous variations in health spending exist.²⁰ Health spending is a complicated product of national, international, and subnational policy decision-making, the supply and demand of the health system, economic development, and even war, civil strife, natural disasters and environmental factors increasingly associated with climate change. That's what makes estimation of future spending inherently uncertain. Still, an additional US\$ 274 billion spending on health per year is deemed necessary by 2030 if the international community is to make progress towards SDG 3 – “to ensure healthy lives and promote well-being”.²¹ Figures projected for the mere achievement of SDG 3 health system targets range up to US\$ 371 billion

17 P. Utting, and A. Zammit, “Beyond Pragmatism: Appraising UN-Business Partnerships”, Markets, Business and Regulation Programme Paper Number 1, October 2006, UNRISD, Geneva, [http://www.unrisd.org/unrisd/website/document.nsf/\(httpPublications\)/225508544695E8F3C12572300038ED22?OpenDocument](http://www.unrisd.org/unrisd/website/document.nsf/(httpPublications)/225508544695E8F3C12572300038ED22?OpenDocument).

18 J. Richter, “Public-Private Partnerships for Health: A Trend with no Alternatives?” *Development* 47(2), 2004, pp. 43-48.

19 <https://eurodad.org/files/pdf/1546822-public-private-partnerships-global-campaign-manifesto-1507748444.pdf>.

20 J. Dieleman, et al., “Future and Potential Spending on Health 2015-2040: Development Assistance for Health, and Government, Prepaid Private, and Out-Of-Pocket Spending in 184 Countries”, *The Lancet* 389(10083), 2017, pp. 2005-2030. Available at [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)30873-5/fulltext#tables](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30873-5/fulltext#tables).

21 <https://www.who.int/sdg/targets/en/>.

per year.²² While such targets would demand health promotion and disease prevention initiatives that go well beyond healthcare, it is the healthcare industries that are quickly making the gains.²³ Estimates suggest that global per capita spending on health will raise 50 percent by 2030, with the most significant portion of the increase concentrated in middle-income countries.²⁴ The paradox is that the range of health spending inequalities is expected to span an even larger disparity gap by 2030.²⁵

But is it really a paradox? Many health trajectories exemplify the growing trends of financialization within global health. Two of them deserve to be highlighted, to exemplify the negative externalities that a small number of corporate-owned chains can steer onto the health systems, the governance of global health, and the shrinking of political space for the achievement of the right to health.

Essential medicines, at the crossroad of financial speculations

After over two decades of international diplomatic initiatives and WHO resolutions and strategies,²⁶ a number of legal struggles and formal pronouncements by national Supreme Courts,²⁷ and relentless street protests from civil society organizations across the globe, medicines prices remain out of control. The 'lives over profit' claim still makes a paradigmatic case, perhaps one of the most

sophisticated examples of the implications deriving from the financialization of health. Access to essential drugs, vaccines and diagnostics lingers as a stumbling block along the road to asserting the primacy of the right to health over trade and the monopoly regime around intellectual property (IP) set by the WTO in 1995,²⁸ to the benefit of drug manufacturers.

The lack of access to medicines has historically been a low-income countries' issue, but in the last few years it has become a worldwide problem, as high-income countries also start to encounter major barriers to guaranteeing universal access to medicines. Research and development (R&D) costs persist as one of the best-kept secrets in pharma circles, being often subjected to highly inflated estimates. Thanks to their lobby firepower,²⁹ drug companies have been constantly engaged in a variety of strategies to block competition from generic medicines and strengthen their intellectual property (IP) monopolies via new rounds of bilateral trade agreements. At the same time, the pricing power conferred by their dominant position has allowed them to progressively transform medicines into speculative financial products.³⁰ Costs of new medicines have significantly increased and are putting a staggeringly high burden on health budgets.³¹ On the other hand, the strategic location of ownership of drug companies' IP in tax havens or in low-tax economies in order to minimize their tax burden, is the rule.³² Tax authorities have difficulties in tracking the link between R&D activities and patent location.

- 22 K. Stenberg et al., "Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries," *The Lancet Global Health* 5 (9), 2017, pp. 875–87. Available at <https://www.thelancet.com/action/showPdf?pii=S2214-109X%2817%2930263-2>
- 23 Deloitte, *2019 Global Health Care Sector Outlook: Shaping the Future*, London, Deloitte, 2019. Available at <https://www2.deloitte.com/global/en/pages/life-sciences-and-healthcare/articles/global-health-care-sector-outlook.html>.
- 24 From US\$ 914 in 2014 to US\$ 2072 in 2030 for upper middle-income countries; from US\$ 267 in 2014 to US\$ 525 in 2030 for lower middle income countries; from US\$ 120 in 2014 to US\$ 154 in 2030 for low income countries. See Dieleman, et al., "Future and Potential Spending on Health 2015-2040d Private, and Out-Of-Pocket Spending in 184 Countries", pp. 2005-2030.
- 25 Ibid.
- 26 World Health Organization, "Public Health, Innovation and Intellectual Property Rights," Report of the Commission on Intellectual Property Rights, Innovation and Public Health, WHO, Geneva, 2006. Available at <https://www.who.int/intellectualproperty/report/en/>. More recently, see the report of the UN Secretary-General's High Level Panel on Access to Medicines, released in 2016, <http://www.unsgaccessmeds.org/final-report>.
- 27 ,E.g., the struggle over the decision of the South Africa Supreme Court on the legal action pursued by 39 drug makers against the government in 1997 over AIDS treatments, which finally dropped the case in 2001 upon request of transparency about their balance sheets; years later, came the instance of the Supreme Court of India which in 2013 dismissed Swiss pharma giant Novartis AG's appeal for a patent for its life-saving cancer drug marketed under brand name Glivec in most parts of the world. Five years after Novartis' challenge to India's anti-evergreening safeguard — Section 3(d) — the case was struck down by India's Supreme Court. See https://en.wikipedia.org/wiki/Novartis_v._Union_of_India_%26_Others
- 28 https://www.wto.org/english/docs_e/legal_e/27-trips.pdf.
- 29 Corporate Power, *Policy Prescriptions: the Firepower of the EU pharmaceutical lobby and implications for public health*, 2015. Available at https://corporateeurope.org/sites/default/files/20150904_bigpharma_web.pdf.
- 30 I am of the opinion that we can consider drugs like financial derivatives. Their values derive from the performance of other 'underlying' entities, such as assets, indexes, currency exchange rates, or a variety of options (e.g., to buy and sell the derivative at an agreed price during an agreed period of time). Derivatives may be exchange-traded on public financial exchange terms, or "over the counter" (when there is a private agreement between financial speculators). In the case of some recent innovative drugs, we have been confronted with secret over-the-counter negotiations between the drug producing speculator and some of the individual health ministries in Europe, just to mention specific cases.
- 31 H. Kuchler, "Novartis wins approval for the most expensive drug", *Financial Times*, New York, 24 May 2019, <https://www.ft.com/content/10086870-7e50-11e9-81d2-f785092ab560>.
- 32 T. Karkinsky and N. Rieder, "Corporate Taxation and the Choice of Patent Location", *Journal of International Economics*, 2012. Available at: <https://doi.org/10.1016/j.jinteco.2012.04.002>. On this topic, see also Ernst and Young, *Global Taxation of Intellectual Property: New and Emerging Tax Policies Create High Stakes Balancing Act*, 2016. Available at [https://www.ey.com/Publication/vwLUAssets/EY-global-taxation-of-intellectual-property-20160518.pdf/\\$FILE/EY-global-taxation-of-intellectual-property-20160518.pdf](https://www.ey.com/Publication/vwLUAssets/EY-global-taxation-of-intellectual-property-20160518.pdf/$FILE/EY-global-taxation-of-intellectual-property-20160518.pdf)



Ebenator community health centre, Anambra state, Nigeria. Picture credit: Christian Aid / Tom Saater

A case in point, and a reservoir of constructive indignation, is the California-based Gilead Science's *transformative approach* to the problem of drug access in setting the price of the new lifesaving Hepatitis C medication (HCV) Sofosbuvir, approved by FDA in December 2013. The drug was first marketed under the name Solvaldi at the cost of US\$84,000 (US\$1,000 per pill) for full treatment of 12 weeks. The cost of manufacturing the original drug was under US\$1,400, and with a significant contribution from tax payers' money. Gilead approached several generic manufacturers in India to sign voluntary licensing agreements for the production of the same drug, priced US\$ 900 for low income countries. The licensing agreement had restrictions prohibiting generic companies from exporting the licensed HCV products to middle-income countries, where the disease is prevalent, potentially excluding millions of patients living with HCV from access to treatment.³³ Public

health professionals and experts across the global South united to reveal treatment barriers. Egypt, India, Brazil and Ukraine challenged the company's patent application, on the grounds that Gilead had privatized publicly funded research.³⁴ Governments from the global North secretly negotiated price reductions with Gilead, to expand access.

A key investigative report³⁵ found that Gilead's sales and profits had tripled since the drug launch - from US\$ 11.2 billion in 2013 to US\$ 32.6 billion in 2015. But, over the same period, Gilead's worldwide effective tax rate plummeted by 40 percent—dropping from 27.3 percent in 2013 to 16.4 percent in 2015. The company had shifted most of the US profits generated from its exorbitantly priced drug to Ireland, and via two Irish subsidiaries to the Bahamas, a tax haven.³⁶

33 <https://www.msfindia.in/msf-access-campaign-response-gileads-deal-generic-companies-sofosbuvir-and-ledipasvir/>

34 <http://www.treatmentactiongroup.org/content/hepatitis-cure-sofosbuvir-turns-5-majority-people-still-not-treated>

35 Americans for Tax Fairness , *Gilead Sciences Price Gouger, Tax Dodger*, July 2016, <https://americansfortaxfairness.org/files/ATF-Gilead-Report-Finalv3-for-Web.pdf>

36 <https://americansfortaxfairness.org/irish-media-confirms-atf-claims-about-gilead-sciences-massive-profit-shifting/>

Universal Health Coverage



Universal Health Coverage (UHC), the prevailing discourse for the health chapter of the SDGs, was originally designed with the explicit recognition of two important aspects of public health. By prescribing a central role to the state in securing funding for healthcare and in regulating the quality and range of services, UHC acknowledged market failures. It also implied that health is a public good, and that the state has the responsibility to secure equitable access to health services. From the earliest mention of UHC at the 58th World Health Assembly in 2005, the focus was placed on “sustainable health financing”.³⁷ “The underlying belief appeared to be that if the finances were secured, provisioning of health services could be taken care of by a variety of mixes that involved both the private and the public sector”,³⁸ in the name of financial inclusion and the extension of financial services to low-income communities. This meant giving up the aspiration of a national health system conceived as an integrated network of services situated at primary, secondary and tertiary levels of care, and replacing it with a scenario of dispersed facilities and service providers, tailored according purchasing powers.

Although UHC is broad enough to include a range of publicly managed financing solutions, today it is one of the driving institutional pathways that are stimulating and delivering the penetration of private finance into the social arena of health, at country level. With different shapes, UHC is overall featured by concerted efforts to promote models of healthcare financing based on *affordable* user fees and voluntary health insurance schemes, alongside the expansion of privately-owned healthcare infrastructures.³⁹ In this way, loan-based approaches like microfinance are opening up new opportunities for rent seeking from the poor, while inviting individual citizens “to organize their daily lives through active individual

risk management, and engage with financial markets through purchase of loans and insurances”,⁴⁰ transforming them from *right holders* to *investing subjects*, individually confronted with the volatility of financial markets against the risks of life events.

But the renewed invitation to live by finance is not limited to the world’s poor, it is wildly taking over in societies that had universal national health systems in place, like the UK and Italy, generally producing deepened inequities, spiralling costs and market concentration.⁴¹ In Italy, where the universal public health system has been essential to the social and economic development of the country and still today accounts for the population’s high life expectancy,⁴² this is progressively being sliced and dismissed to the advantage of private insurance schemes. In the face of an aging society, the health budget was trimmed by 25 billion Euros between 2010 and 2012,⁴³ local health units were dismantled (from 642 in the 1980s to 101 in 2017), and 175 hospitals closed down, accordingly. The compelling title of the 2018 Censis-Rbm report – *Resentment Healthcare, Resentment for Healthcare: Scenes from an Unequal Country*⁴⁴ - illustrates the disquieting portrait of an out of control “out-of-pocket-society”. Private disbursement for health services increased by 9.6 percent from 2013 to 2017, forcing over 7 million people to go into debt, or sell their houses (2.8 million) to access their constitutional right to healthcare. Considering the important role of the public health system in advancing social and economic development in the past decades, its progressive sale to private insurance schemes for an easy colonization of the Italian ageing society can be described as a perfect storm. And a perfect crime against common sense.

37 https://www.who.int/health_financing/documents/cov-wharesolution5833/en/, para 58.33

38 People’s Health Movement, Medact. Medico International, Third World Network, Alames, *Global Health Watch 4: An Alternative World Health Report*, Zed Books, London, 2014, p. 77.

39 B. Hunter and S. Murray, “Deconstructing the Financialization of Healthcare,” *Development and Change* 0(0), 2019, pp. 1–25.

40 *Ibid.*, p. 11.

41 *Ibid.*, p. 4.

42 Bloomberg, *Most Efficient Health Care Around the World Report*, 2014. Available at <https://www.bloomberg.com/graphics/infographics/most-efficient-health-care-around-the-world.html>. In this regard, see also <https://www.bloomberg.com/news/articles/2017-03-20/italy-s-struggling-economy-has-world-s-healthiest-people>

43 F. Carraro and M. Quezel M., *Salute SpA: La Sanità Svenduta alle Assicurazioni*, Chiarelettere, Milano, 2018.

44 https://www.sanita24.ilsole24ore.com/pdf2010/Editrice/ILSOLE24ORE/QUOTIDIANO_SANITA/Online/_Oggetti_Correlati/Documenti/2018/06/07/CENSIS_RBMSintesi.pdf?uuid=AEm4gx0E.

Raising questions about the financialization of global health



Healthcare markets are growing with little concern for their long-term effects on health and equity. The global expansion of healthcare models that extract revenues from situations of vulnerability, in the name of sustainable development, is a stark contradiction. In fact, long-term escalation of costs has been documented both in the global North and in the global South.⁴⁵

Beyond the health domain, the euphoria for financialization seems to have definitely captured international development circles, primarily by means of multi-stakeholder partnerships. Escorting private finance into development is increasingly promoted by alliances of multilateral institutions, national governments, owners of equity investment funds and private capital. The assumption is that *multi-stakeholderism* may be the solution to the current problems with the multilateral system,⁴⁶ and that resorting to private money is the inevitable strategy if the world is to catch up for the estimated annual gap of US\$ 2.5 trillion required to achieve the SDGs – a gap considered beyond the capability of public funding.⁴⁷ The 2015 Addis Ababa Action Agenda on financing for development, also, placed emphasis on the need to use public funds to expand privately financed and owned infrastructure.⁴⁸ On the other hand, financial aid volumes continue to fall short of targets and the proportion of it going to countries is falling dramatically.⁴⁹ In this scenario, the acceptance of an argument that makes poverty bankable finds no institutional resistance. The World Bank has successfully built a coalition to effectively advance its “Maximising Finance for Development” (MFD) agenda, persuading developing country governments to finance subsidies and other de-risking measures to guarantee private capitals and ensuring that they supply securities preferred by transnational banks and institutional investors.⁵⁰

There has never been a more thrilling time to be an investor in health, especially now that the combined burden of communicable and non-communicable diseases is sharpening perceptions on the needs for health in lower-income countries. In a nutshell, this appears the message that the WHO aims to convey with its Triple Billion target investment case,⁵¹ with details on how much economic return will result from supporting the organization that has been always stunted financially over the past decades. Cost-benefit analyses of the projected next five years are a direct legacy of the 1993 report. At the same time, “healthcare financialization represents a new phase of capital formation that builds on, but is distinct from, previous rounds of privatization and neoliberal healthcare reform, and this is manifested in the creation of new asset classes”.⁵² Such new asset classes include *impact bonds* (like the Cameroon Cataract Performance Bond)⁵³ or *catastrophe bonds* like the international health outbreaks’ insurance Pandemic Emergency Financial Facility.⁵⁴

The financialization of global health poses a series of issues. A few of these are:

- a governance issue, due to the fragmentation produced in the health system and the hybridization of the role of health institutions at all levels (from international to local), which is bound to favour the impotence of the public function;
- a democratic issue: financial markets are based on private agreements, and investors tend to make their strategies, datasets, risk assessment models and internal reports confidential. While the use of public funding can in theory be traced, the same does not apply to private sector investments; this means that there are fundamental knots in terms of transparency and accountability to the society; this presents a challenge to public interest dynamics as they embody an inevitable diversion from core values of equity and social justice;

45 Hunter and Murray, “Deconstructing the Financialization of Healthcare,” p. 16.

46 H. Gleckman, “How the United Nations is quietly being turned into a public-private partnership: A new agreement with the World Economic Forum gives multinational corporations influence over matters of global governance”, *Open Democracy*, 2 July 2019. Available at <https://www.opendemocracy.net/en/oureconomy/how-united-nations-quietly-being-turned-public-private-partnership/>.

47 Hunter and Murray, “Deconstructing the Financialization of Healthcare.”, p. 1

48 United Nations, *Addis Ababa Action Agenda of the Third International Conference on Financing For Development*, 2015. Available at https://www.un.org/esa/ffd/wp-content/uploads/2015/08/AAAA_Outcome.pdf.

49 <http://devinit.org/post/investments-to-end-poverty-2018/>, p.6.

50 <http://www.ipsnews.net/2019/04/world-bank-financialization-strategy-serves-big-finance/>.

51 World Health Organization, “A Healthier Humanity: The Who Investment Case for 2019-2023”, Geneva, 2018. Available at <https://apps.who.int/iris/handle/10665/274710>.

52 Hunter and Murray, “Deconstructing the Financialization of Healthcare,” p. 8.

53 Ibid.

54 F. Stein and D. Sridhar “The Financialization of Global Health, *Wellcome Open Research*, 2018, p.17.

- a market-related issue: financial markets are notorious for boom- and-bust cycles. In financializing global health, healthcare provision may be exposed to the casino dynamics seen before and with the 2008 global financial crisis, putting impoverished population at immense risk;
- a cultural issue: financialization may well influence health consumerism, and people's notion about the healthcare approach to be considered feasible, and desirable. Market tools are never neutral, and several moral tensions exist in the domain of health, which is in the end the domain of human life.¹

While the right to health is constantly redesigned to play an ancillary role to financial markets, the global health community needs to urgently raise the visual spectrum beyond diseases to better understand and address the speculative dynamics of finance advancing in the health sector, with little promise of sustainability. Global organized reaction to move away from the model of public-private financing and ensure that the benefits of public investment remain in public hands is emerging, thanks in part to the new climate emergency conscience. These are signs of mobilization and activism that cannot be ignored, and which must stay connected.

1 Ibid.



Citizens for Financial Justice is a diverse group of European partners – from local grassroots groups to large international organizations – with a shared vision of informing and connecting citizens to act together to make the global finance system work better for everybody.

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