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Private Financial Actors and Financialisation in Global Health

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Table of contents

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BRIEFING PAPER

Power & Accountability | JANUARY 2025

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Written by Benjamin M. Hunter (University of Glasgow), David McCoy (UNU IIGH), Ana Carolina Cordilha (University of Rennes), Anna Marriott (Oxfam), Victor Roy (University of Pennsylvania), Felix Stein (University of Amsterdam) and Benjamin Wood (Deakin University).

Executive Summary

The era of the Sustainable Development Goals has become the era of private finance. Decades-long political, economic and social trends have seen rapid growth in the size and scale of private finance relative to public finance, and the increasing political power of private financial actors. In global development, this has taken form in narratives and actions that establish and quantify investment gaps, call for greater and greater levels of private finance to fill these gaps, and create new financial instruments with which to realise the expansion of private financial capital. These changes are sometimes referred to as 'financialisation'.

This briefing paper responds to the expansion of private finance in global health, demystifying the process of financialisation and offering a vital counter-perspective to an increasingly pervasive but questionable narrative that positions private finance as necessary to the future of global health. The paper charts the expansion of private finance across global health, pointing to how actors once marginal to this sector are becoming central to its financing and governance. Drawing on several case studies and a growing body of evidence, the briefing paper highlights three overlapping concerns associated with the financialisation of global health: the high cost of private investment; the undermining of public health principles and values; and the weakening of democratic governance and regulatory capture by powerful private financial actors.

The paper raises the alarm that many aspects of financialisation in global health are harmful and calls for three sets of action:

1. challenge the common fallacies and false narratives regarding private finance and associated financial instruments;
2. press for change in public and multilateral policy and practice;
3. advocate for alternative models of financing and governance that are more strongly rooted in the public interest.

Introduction

When Dubai-based private equity firm Abraaj Group launched its Growth Markets Health Fund in 2015, it had an ambitious plan to raise USD 1 billion to invest in for-profit healthcare companies in low- and middle-income countries (LMICs). Several high-income country governments, multilateral organisations and private investors signed up to contribute to the fund. The following year, the World Bank launched its Pandemic Emergency Financing Facility (PEF) to much praise, claiming to have raised USD 425 million from private investors to distribute to countries in the event of a pandemic.

In today's global policy context, such modes of 'innovative' health financing are encouraged and celebrated in many global health quarters. And yet, both the Growth Markets Health Fund and the PEF are notable for their failures. Abraaj, which has since been liquidated, was engaged in large-scale deception and unauthorised use of investor funds, while the hospitals it invested in have been accused of operating like a 'cut-throat business' and committing human rights violations.[1] [2] Similarly, the PEF is now subject to widespread criticism over its substantial costs and the inability of LMICs to quickly access funds when experiencing health emergencies. [3] [4]

Despite these failures, and many others like them, many global health actors continue to court private finance as necessary to the future of global health. The purpose of this briefing paper is to challenge this perspective by improving awareness and understanding of key trends involving private finance and global health and the risks entailed.

- Section 1 reviews the political and economic conditions that have enabled and encouraged private finance to expand its role within global health, as part of a wider set of processes of financialisation, and the forms this has taken.
- Section 2 discusses three main concerns with recent trends: the direct and indirect costs of private finance; the distortion of policy agenda and institutions towards financial logic; and the weakening of government influence and accountability.
- Section 3 lays out a framework for change, emphasising the need to challenge prevailing narratives, press for greater attention to inclusion and democratic accountability, and advocate for alternative models of financing built on principles of justice.

Most people working in public health may not be familiar with the world of finance, and we have therefore produced a glossary of key financial terms in an appendix at the end of this paper. If you are unfamiliar with the world of finance, we encourage you to read the appendix first.

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[1] Owaahh, 2020. Customers, Not Patients: The Nairobi Women's Hospital Saga. The Elephant, Feb 6. Available from: https://www.theelephant.info/analysis/2020/02/06/customers-not-patients-the-nairobi-womens-hospital-saga/
[2] Oxfam, 2023. Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped.
[3] Brim B and Wenham C, 2019. Pandemic Emergency Financing Facility: struggling to deliver on its innovative promise. BMJ Global Health, 367:l5719.
[4] Stein F and McNeil D, forthcoming 2025. Blended finance to the rescue: Subsidies, vaccine bonds and matching funds in global health. Global Public Health

1. Background

1.1. Financialisation

The expansion of private finance within global health reflects a wider set of political, economic and technological changes that began in the second half of the 20th century, a process that has come to be known as financialisation. There are varying definitions of this term in the literature. According to one, financialisation is 'the increasing dominance of financial actors, markets, practices, measurements and narratives, at various scales, resulting in a structural transformation of economies, firms (including financial institutions), states and households'.[5]

In practical terms, this entails the increasing subordination of public institutions, private companies and human lives to the interests and demands of finance capital and the financial industry, mainly through processes of privatisation, commodification and assetisation.[6] Through financialisation, the provision of public services has become increasingly reliant on private investment and private for-profit companies owned by, and indebted to, private financial actors.[7] Private companies themselves have turned to financial products to generate profits rather than through commodity production and trade. Public resources are thus being redirected to private financial actors through various direct and indirect channels, ultimately to be accumulated as wealth by a small segment of global society. In essence, financialisation has shifted private finance ever further away from serving economies to aggressively extracting profits from society.

The groundwork for this was laid by the rising influence of neoliberal economic theory in public and social policy, which abandoned ambitions to construct and maintain welfare states and replaced these with privatisations, cuts in public spending, and a general reorientation towards private, market-based modes of provision and financing. These policies, known as the 'Washington Consensus', were advanced in LMICs by the World Bank and International Monetary Fund (IMF), whose loans and grants came with conditions of deregulation and privatisation,[8] including social sectors such as healthcare where governments were argued to be crowding out the efficiency and innovative capabilities of the market and private sector.

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[5] Aalbers MB, 2017. Corporate financialization in Richardson D, Castree N et al (Eds), The International Encyclopedia of Geography: People, the Earth, Environment, and Technology. Wiley-Blackwell
[6] Birch K and Muniesa F, 2020. Assetization: Technoscientific Capitalism. In Birch K and Muniesa F (Eds). Turning Things into Assets in Technoscientific Capitalism. MIT Press.
[7] Simon A, Penn H, Shah A et al, 2021. Acquisitions, Mergers and Debt: the new language of childcare – Main Report. UCL Social Research Institute.
[8] Kentikelenis A and Stubbs T, 2023. A Thousand Cuts: Social Protection in the Age of Austerity. Oxford University Press

The deregulation of financial services and of trade and investment policies led to an unprecedented increase in the volume, speed, and reach of financial flows, and to the size and power of financial institutions. Over subsequent decades, as companies became financialised, they focused less on the production or distribution of goods and more on the stories they needed to tell to attract additional investment. The movement of finance between countries was liberalised, global financial markets became increasingly integrated, and new digital technologies and financial innovations facilitated cross-border operations. This allowed funds to circulate more freely across borders, while private financial actors acquired unparalleled capacity to organise and influence these flows of finance, multiplying the funds they manage through loans, investments, and speculation in financial markets.

A relatively small number of private financial actors have emerged to become the largest shareholders in many publicly listed and private companies across diverse sectors in North America, Western Europe, and increasingly elsewhere. Today, the world's largest asset management companies manage a volume of assets worth more than the gross domestic product (GDP) of several countries; the top 500 asset management companies collectively manage USD 114 trillion in assets.[9] Their activity is shaped by the opaque assessments made by private credit ratings agencies which increasingly gate-keep access to debt and a host of financial intermediaries, such as investment banks, corporate lawyers and consultants, who earn vast fees from developing new financial products.

This unprecedented regime of corporate governance by financial actors, referred to as 'asset manager capitalism',[10] has provided financial actors with an outsized influence over entire economies and enhanced the wealth of a small segment of society - the richest 1% of people presently own 43% of all global financial assets.[11]

A major social concern about asset manager capitalism is its reinforcement of 'shareholder primacy' and forms of corporate governance that prioritise the maximisation of shareholder returns above other such as the use of any surplus revenue to reduce environmental pollution, improve worker well-being or invest in future production capabilities. Shareholder primacy promotes extreme forms of profiteering and is accompanied by less investment in socially meaningful innovation and important but unprofitable social and welfare services. It encourages 'rent-seeking' - a process of wealth extraction and accumulation that is usually based on some form of 'privilege' such as ownership of assets like land and intellectual property, or the acquisition of monopoly/oligopoly control over critical infrastructure (eg. telecommunications platforms or roads) and services (eg. water and energy provision). Such forms of wealth generation are associated with exploitation and underprovided, poor quality, and/or excessively priced products or services (including those necessary for meeting essential needs, including health, education, housing and food).

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[9] Thinking Ahead Institute, 2023. The World's Largest 500 Asset Managers. Available from: https://www.thinkingaheadinstitute.org/content/uploads/2023/10/PI-500-2023-1.pdf
[10] Braun B, 2021. Asset Manager Capitalism as a Corporate Governance Regime. In Hacker JS, Hertel-Fernandez A, Pierson P and Thelen K (Eds), The American Political Economy: Politics, Markets, and Power. Cambridge University Press, New York.
[11] Oxfam. 2024. Inequality Inc. How corporate power divides our world and the need for a new era of public action.

What is also tangible is the deepening penetration of personalised forms of private finance across ever more areas of life. For example, more and more people now have to get into debt to access basic goods and services, while citizens are reconfigured as personally responsible "investors" in their own health, education, job prospects and pensions.[12] In LMICs, attempts to promote greater access to credit and 'financial inclusion' have transformed poverty into a financial problem to be solved through further indebtedness to financial institutions,[13] while social protection systems languish and households find themselves ill-equipped to respond effectively to emerging crises.[14] Impoverished populations and sectors with poor profitability are usually disregarded due to their poor 'bankability' prospects, until such time that financial 'innovations' can open them up as new markets for investment.

The combined effect of these trends on society has been a creeping dominance of and reliance upon private financial actors. National governments and multilateral organisations have embraced and encouraged an ever-growing interdependence between public and private finance, including in essential services and sectors such as water, housing and social care. Public utilities that underwent privatisation are now increasingly controlled by private finance looking to capitalise on the guaranteed income streams offered by government budgets and household payments. At the same time, governments respond to insufficient public budgets by borrowing from private financial markets rather than implementing policies to generate more public revenue. Almost two-thirds of LMIC debt (62%) is owed to private creditors, up from 47% in 2010.[15] This reliance on private finance also exacerbates geographic inequalities as poorer countries face higher borrowing costs than wealthier countries, feed into cycles of sovereign debt and financial crisis, and complicate debt restructuring due to the fragmented and commercial creditor interests involved.[16]

Presently, multilateral organisations are positioning themselves as brokers for private finance that they claim can provide the USD 3.9 trillion needed to achieve the Sustainable Development Goals (SDGs).[17] In this context, policy actors have coalesced around the idea, as set out in the World Bank's Billions to Trillions report[18], that public funds including development aid should be used to subsidise private finance and incentivise private investment in projects that are 'developmental' and/or 'poverty-reducing'. Public funds are used to draw in private investment in various ways, often through forms of so-called 'blended finance'.[19] This can involve public agencies or private foundations making co-investments with private investors or offering guarantees and insurances to mitigate risk or repay investors in the event of losses. In this, the 'Washington Consensus' has now been superseded by a 'Wall Street Consensus' in which the involvement of private investors is 'de-risked'[20] so that private investors can be protected from losing money and encouraged to have deeper and wider influence over national and global economies.

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[12] Van der Zwan N, 2014. Making sense of financialization. Socio-Economic Review, 12(1):99-129
[13] Mader P, 2018. Contesting financial inclusion. Development and Change, 49(2): 461-83
[14] Villar E, Francke P and Loewenson R, 2024. Learning from Perú: Why a macroeconomic star failed tragically and unequally on Covid-19 outcomes. SSM-Health Systems, https://doi.org/10.1016/j.ssmhs.2023.100007
[15] UN Global Crisis Response Group, 2023. A world of debt: A growing burden to global prosperity.
[16] Tan C, 2022. Private Investments, Public Goods: Regulating Markets for Sustainable Development. European Business Organization Law Review, 23:241–271
[17] OECD, 2023. Global Outlook on Financing for Sustainable Development 2023: No Sustainability without Equity.
[18] World Bank, 2015. From billions to trillions: transforming development finance. https://pubdocs.worldbank.org/en/622841485963735448/dc2015-0002-e-financingfordevelopment.pdf
[19] Pereira J, 2017. Blended Finance: What it is, how it works and how it is used. Oxfam and Eurodad.
[20]Gabor, D. 2021. The Wall Street Consensus. Development and Change, 52(3): 429-59

1.2 Financialisation in health

Private finance took a foothold in national healthcare systems in the 1970s. The USA was at the forefront of these changes, with reforms in the public funding of healthcare creating an environment that fostered the growth of healthcare corporates[21] - a type of organisation that is amenable to private financial investment. Corporate healthcare provision expanded quickly, contributing to spiralling public and out-of-pocket healthcare spending, and US healthcare became a focal point for private equity, a type of private investor that focuses on corporations that are not listed on stock markets.

While the USA has been a key market for private equity deals in healthcare, with buyouts totalling USD 749 billion between 2010-2020,[22] similar patterns of private equity-fuelled growth in corporate healthcare are spreading to other settings. It is particularly prominent in middle-income countries that lack comprehensive public healthcare systems and where the growth of corporate healthcare provision since the 1990s has been closely followed by rising private equity investment,[23] including by large asset management companies such as Blackstone.[24]

In high-income countries that have more extensive public healthcare systems, financialisation has involved governments actively looking to private finance for additional investment and to help manage public debts. This includes the use of bonds, loans, guarantees, subsidies and risk mitigation instruments, as well as regulatory reforms, to create a favourable environment for financial institutions and markets. For example, in 1996 the French government created a new agency to convert social security debts (a large proportion of which were for healthcare) into products that could be sold in financial markets (see Case 7 later).[25] Additionally, in the UK, the government embarked on a programme of 'private finance initiatives' to draw in private finance for the construction of new hospitals.

Related trends are now evident in many middle-income settings. In Brazil, local health funds, who usually act as decentralised 'financial managers' of the public sector, have become investors themselves. They now invest public funds in short-term financial assets in order to generate monetary returns that can then be invested into healthcare service provision. Meanwhile, Brazil's non-profit and charitable hospitals that form part of the public healthcare system rely on private borrowing to such an extent that a portion of public revenues are now earmarked to cover their interest payments.[26]

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[21] Bruch R, Roy V and Grogan CR, 2024. The Financialization of Health in the United States. New England Journal of Medicine, 390(2): 178-182
[22] Scheffler RM, Alexander LM and Godwin JR, 2021. Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk. American Antitrust Institute and Petris Centre, University of California, Berkeley
[23] Hunter BM and SF Murray, 2019. Deconstructing the Financialisation of Healthcare. Development and Change, 50(5): 1263-1287
[24] Jayakumar PB, 2024. PE's Healthcare Takeover. Fortune India. Available from: https://www.fortuneindia.com/long-reads/pes-healthcare-takeover/117415
[25] Cordilha AC, 2021. Public health systems in the age of financialization: lessons from the French case. Review of Social Economy, 81(2), 246–273.
[26] Cordilha AC, 2023. Public health systems in the age of financialization: lessons from the Center and the Periphery. Brill Press.

At an international level, the expansion of private finance in global health began in the 2000s and accelerated following the 2008 Global Financial Crisis.[27] [28] Public-private partnerships (PPPs) such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Gavi, encouraged and enabled greater participation in global health by transnational corporations, followed by involvement of the financial services industry. In 2006, Gavi, launched its International Finance Facility for Immunisation (IFFIm) to raise funds from private investors for vaccine procurement. Enthusiasm for private financing options has since spread.

By 2008, an initiative led by the World Bank's private sector arm, the International Finance Corporation (IFC), and backed by the Bill and Melinda Gates Foundation, the African Development Bank and the German Development Finance Institution (DEG) was openly canvassing for more private investment into Africa's healthcare systems via private equity vehicles and loans.[29] The health sector in LMICs quickly became the target for a series of private investment funds that looked to combine public and private investment to encourage the expansion of healthcare corporations. More recently, the World Bank-hosted Global Financing Facility for Women, Children, and Adolescents (GFF) launched a blended financing initiative that uses GFF grants to 'de-risk' investments for the IFC and private finance, including in projects like the Africa Medical Equipment Facility.[30]

Development organisations have also been central to these trends. The IFC alone reports having invested over USD 9 billion in private health in LMICs, with a current active portfolio worth USD 3.6 billion.[31] Bilateral and regional development finance institutions (DFIs) such as the UK's British International Investment, France's Proparco and Germany's DEG have followed suit[32] [33] and frequently utilise financial intermediaries to manage and invest their funds. Of nearly 360 health investments made by four European DFIs over the last decade, more than 80% were made via financial intermediaries, mostly private equity funds.[34] This has created new commercial opportunities for private fund management companies, as well as the wider investment banking industry that designs, funds and mediates transactions. Since 2017, there have been at least 115 new private equity investments in hospital services across Asia, Africa and Latin America, including 45 buyouts and 70 so-called 'growth investments'. 2023 saw 29 deals alone spanning 12 countries.[35]

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[27] Stein F and Sridhar D, 2018. The Financialisation of Global Health. Wellcome Open Research, 3(17).
[28] Hunter BM and SF Murray, 2019. Deconstructing the Financialization of Healthcare. Development & Change, 50(5):1263-87
[29] Oxfam, 2014. Investing for the few: the IFC's Health in Africa initiative
[30] Akina Mama Wa Afrika and Wemos, 2022. The Africa Medical Equipment Facility (AMEF) in Kenya: Does this new blended finance facility contribute to equitable access to healthcare services?
[31] International Finance Corporation, 2024. IFC's Work in Health https://www.ifc.org/en/what-we-do/sector-expertise/health#ataglance (last checked November 2024)
[32] Hunter, BM, 2023. Investor States: Global Health at the End of Aid. Cambridge University Press. ISBN 9781009209557 (doi: 10.1017/9781009209564)
[33] Oxfam, 2023. Sick Development: How rich-country government and World Bank funding to private hospitals causes harm, and why it should be stopped
[34] Oxfam, 2023. Sick Development: How rich-country government and World Bank funding to private hospitals causes harm, and why it should be stopped
[35] Bugbee M, 2024. Private Equity's Hospitals in low- and middle-income countries. https://pestakeholder.org/news/private-equity-is-buying-up-hospitals-in-low-and-middle-income-countries-with-the-help-of-development-finance-institutions/ Private Equity Stakeholder Project.

These trends have also been encouraged by the general adoption of a conceptualisation of 'universal health coverage' (UHC) that encourages social and private health insurance and extensive private provision.[36] These modes of healthcare financing and provision create substantial scope for the involvement of another set of private financial actors, private insurance companies[37] to grow in the health sector by operating social health insurance schemes or selling their own private insurance products, frequently referred to as 'supplementary' to social health insurance schemes. Insurance companies have also co-created new global health insurance products such as the World Bank's PEF and were enlisted to protect pharmaceutical manufacturers against liability claims in relation to COVAX - the COVID-19 vaccine facility.[38]

These changes have been mirrored in other sectors impacting on health. Speculation by financial actors on food commodities has generated huge returns for investors but exacerbated price volatility.[39] In health-harming industries such as alcohol and ultra-processed foods (UPFs), large investors in leading companies have played down concerns about their contribution to the rising burden of non-communicable diseases and impeded corporate policies aimed at improving health and sustainability (see Case 1). Across economies, shareholder primacy has undermined the health and well-being of workers by legitimising and promoting job cuts and reductions in wages and pensions.

With surging levels of private investment in public utility infrastructure, residential housing and farmland, a small number of financial actors have now gained considerable control over many of the essential physical structures and systems upon which people's health depends. Such developments now leave many societies vulnerable to the tendency of profit-hungry institutions to deliver poor quality and/or excessively priced essential utilities (including electricity, water and sanitation). The growing reach of asset management companies in the housing sector has inflated housing rents and increased eviction rates alongside devastating health impacts[40] while speculative investments in farmland have been associated with shifts in food production away from healthy, sustainable, and culturally appropriate diets towards the production of a more limited set of crops used mostly as inputs for UPF manufacturing and intensive meat and dairy production.[41] The impacts are most detrimental to women whose already unequal and unpaid care loads disproportionately increase as access to essential utilities declines.

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[36] Kumar R and A Birn, 2023. Going Public: The Making and Unmaking of Universal Healthcare. Cambridge University Press.
[37] Murray SF, 2024. The Problem of Private Health Insurance: Insights from Middle-Income Countries. Cambridge University Press
[38] Stein F, 2021. Risky business: COVAX and the financialization of global vaccine equity. Globalization and Health, 17, 112.
[39] Friel S, Schram A, Frank N et al, 2024. Financialisation: a 21st century commercial determinant of health equity. Lancet Public Health, 9:e705-8
[40] Christophers B, 2023. Our Lives in Their Portfolios: Why Asset Managers Own the World. Verso
[41] Smith K and Lawrence G, 2021. Finance's Social License? Sugar, Farmland and Health. International Journal of Health Policy and Management, 10, 957-967

Case 1: UPFs and fast-food corporations

UPF manufacturers and fast-food corporations are emblematic of how health and environmental concerns are sidelined to give shareholders quick financial returns. Between 2019 and 2021, the UPF manufacturers and food service corporations (the largest of which were mostly fast-food corporations) listed on US stock exchanges transferred the equivalent of approximately 10.4% (~USD 177 billion in 2021 USD) and 11.9% (~USD 62.7 billion in 2021 USD) of their revenues to their shareholders, respectively. This has risen sharply from 30 years ago, when the equivalent figures for 1990-1992 were approximately 3.1% (~USD 41.1 billion in 2021 dollars) and 1.1% (~USD 2.36 billion in 2021 dollars).[42]

Large private investors, including those described by some as 'activist investors', because of their active and hands-on involvement in company governance and decision-making,[43] have sought to maximise their short-term returns by compelling corporate executives to cut costs and liabilities and maximise opportunities to externalise social and environmental costs. One example is Danone, one of the world's largest food corporations, where a campaign led by hedge fund 'activists' in 2022 weighed in the dismissal of Emmanuel Faber, Danone's Chief Executive Officer, because Faber's focus on environmental sustainability was seen as a threat to the company's capacity to maximise short-term profits.[44]

Large investors have also voted against resolutions put forward by other shareholders that call on UPF manufacturing and fast-food corporations to integrate public health and other socio-ecological objectives into their operations. One analysis of shareholder voting data for leading UPF and fast-food corporations in the USA showed that between 2012 and 2022, the 'Big Three' asset managers (BlackRock, Vanguard, and State Street) had voted against all shareholder resolutions on issues relating to public health, lobbying and political influence[45] as well as against most other resolutions on social and environmental issues.[46]

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[42] Wood B, Robinson E, Baker P et al, 2023. What is the purpose of ultra-processed food? An exploratory analysis of the financialisation of ultra-processed food corporations and implications for public health. Globalization and Health, 19(1), 85

[43] Engelen E, Konings M and Fernandez R, 2008. The rise of activist investors and patterns of political responses: lessons on agency. Socio-Economic Review, 6(4):611-636

[44] Van Gansbeke F, 2021. Sustainability and the Downfall of Danone CEO Faber. Forbes. Retrieved 6 May 2022 from: https://www.forbes.com/sites/frankvangansbeke/2021/03/20/sustainability-and-the- downfall-of-danone-ceo-faber-12/?sh=4d10d1755b16

[45] Excepting abstentions and votes withheld. Wood B, Robinson E, Baker P et al, 2023. What is the purpose of ultra-processed food? An exploratory analysis of the financialisation of ultra-processed food corporations and implications for public health. Globalization and Health, 19(1), 85

[46] The cited study did not include an analysis of the details of the shareholder resolutions. BlackRock told the authors of this paper that it is "misleading to suggest all E,S and G [Environmental, Social and Governance standards] are unequivocally good for companies". They said "the proposals can often be overly prescriptive and unable to be implemented, they may be repetitive to something a company is already doing, and/or they may not be material to a company's long-term financial growth". Email communication 19 November, 2024.

Large private investors want big, reliable and growing companies to generate returns on their investment. Often, profits are generated through the continued production and sale of unhealthy products, usually with aggressive and unethical marketing often disproportionately harming low-income and otherwise marginalised populations. Meanwhile, investors push for enhanced dividends and share buybacks to meet immediate financial demands. For example, in 2017 the US hedge fund Third Point began to pressure Nestlé's executives shortly after acquiring a USD 3 billion stake in the company. Within a short period of time, Nestlé had reportedly complied with many of Third Point's demands, including the implementation of a large share buyback programme.[47] In doing so, company executives chose to prioritise the short-term interests of their shareholders rather than investing in their workers or finding ways to reduce pollution or improve health.

Fundamentally, several finance actors that were previously marginal are now central not just to the financing and commercialisation of healthcare but also to health policy and governance more broadly. They are also now key drivers of many of the social determinants of ill health. These actors include private equity, fund managers, investment banks, pension funds and insurance companies whose expansion into global health has been enabled by a variety of financial instruments that are mostly unfamiliar to those working in global health. In a field historically dominated by public finance, grants and concessional loans, there is now greater and growing use of bonds, insurance products, equity investments and infrastructure PPPs. Many new health initiatives now incorporate such financial instruments as a matter of routine,[48] despite calls from many actors for more equitable, predictable and non-extractive forms of financing.[49] As a consequence, global health governance is increasingly influenced by institutions that are tasked with promoting and regulating private finance rather than by institutions with a mandate to promote public health or the public good. This financialised regime brings new expectations and practices to global health, which we turn to in the next section.

2. Impacts and Implications for Global Health

It is sometimes claimed that the expansion of the financial services industry in global health and development is a 'win-win' arrangement and offers a means by which to achieve global health objectives. As leaders at the World Bank have advocated: "We can play a critical role in finding win-win solutions, where we maximize financing for development, and create opportunities for the owners of capital to make higher returns."[50] There are, however, significant risks and harms in adopting such an optimistic outlook, three of which are outlined below.

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[47] Geller M and Koltrowitz S, 2017. Nestlé plans $27b share buyback amid Third Point pressure. The Australian Financial Review Retrieved 26 May 2023 from: https://www.afr.com/world/europe/nestl-plans- 27b-share-buyback-amid-third-point-pressure-20170628-gwzytk

[48] Development Bank Working Group for Climate-Health Finance, 2024. Development Banks' Joint Roadmap for Climate-Health Finance and Action.

[49] African Union, 2023. The African leaders Nairobi Declaration on Climate change and call to action. Available from: https://media.africaclimatesummit.org/NAIROBI+Declaration+FURTHER+edited+060923+EN+920AM.pdf ?request-content-type=%22application/force-download%22

[50] Kim JY, 2017. Speech at the World Bank Group 2017 annual meetings plenary session, Washington, D.C. World Bank.

2.1 The high cost of private finance

Private finance is typically more costly than public finance. Because private investors expect very high returns within very short time periods, they have to be offered generous deals. Significant inducements are therefore required to incentivise the private financial sector to participate in global health. For example, the interest rates for bonds issued by global health projects are usually priced high to entice private actors to purchase them, and/or incorporate risk mitigations borne by public and multilateral institutions (see Case 2 on the World Bank's PEF). Even if there is some alignment between the interests of private investors and wider societal concerns, it does not dispense with the fundamental fact that high profits are expected by these actors, and that these must be paid for by governments, service users or both.

Case 2: Pandemic Emergency Financing Facility

The Pandemic Emergency Financing Facility (PEF) was launched in 2016 by the World Bank following the Ebola outbreak in Western Africa that killed more than 11,000 people.[51] The failure of the international community to respond rapidly and effectively to the outbreak, and the extensive social and economic harm that resulted, created an impetus for the World Bank to put forward a so-called innovative solution based on private finance.

The official aim of the PEF was to create a financial resource that could be quickly drawn upon in the event of an unfolding outbreak that could become a pandemic, thereby averting a repeat of the delays that occurred during the Ebola outbreak. It also aimed to show the potential for private finance to bolster the resources of global health.[52] The World Bank enlisted US risk modelling company AIR Worldwide (now Verisk) along with the World Health Organisation (WHO) and reinsurers Swiss Re and Munich Re to design the PEF.[53]

The resulting mechanism consisted of two pots of funds. The first – called an 'insurance window' – entailed the World Bank issuing 3-year 'catastrophe bonds' to attract private lending (see Glossary). The money raised through these bonds would be distributed to countries when specific conditions indicating the beginnings of a pandemic are met. If the conditions are never met, the money would eventually return to the private investors. However, given that investors risked losing their investments in the event of a potential pandemic, they would receive high interest payments during the lifetime of the bonds - payments that were made by public donors (multilateral and governmental organisations). The second, smaller pot of funds - called a 'cash window' - was entirely financed by public donors and was to be used in less serious situations where a disease outbreak did not meet the conditions for payment from the larger 'insurance window'.

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[51] World Bank, 2020. Fact Sheet: Pandemic Emergency Financing Facility. Available from: https://www.worldbank.org/en/topic/pandemics/brief/fact-sheet-pandemic-emergency-financing-facility
[52] Erikson S, 2019. Global health futures? Reckoning with a pandemic bond. Medicine Anthropology Theory, 6(3). https://doi.org/10.17157/mat.6.3.664
[53] Brim B and Wenham C, 2019. Pandemic emergency financing facility: Struggling to deliver on its innovative promise. BMJ, 367

Significant flaws in the PEF's insurance window quickly became apparent when it did not provide the rapid funds expected during disease outbreaks. First, the predefined payout criteria were complicated and hard to operationalise (ie. how does one define the beginnings of a pandemic). Second, the payout criteria were too restrictive and inappropriate for the purpose of averting a pandemic. They were designed not with the flexibility and adaptability needed to prevent loss of life, but with the aim of minimising the financial risk to private investors. Astonishingly, no funds from the insurance window were distributed during an Ebola outbreak in Democratic Republic of Congo during 2018-2020, despite more than 2,000 deaths in the country. Instead, by mid-2019 the insurance window had paid out USD 114 million to private investors while eligible countries facing disease outbreaks had received nothing at all.[54] It took COVID-19 for the PEF to eventually meet its payout criteria, and even then, the PEF took four months to liberate the modest sum of USD 196 million from its insurance window.

Ultimately, the PEF never overcame its fundamental structural weakness: it entailed donor governments and the World Bank borrowing money from private financial actors at a much higher cost than would have been the case via tried-and-tested instruments such as sovereign bond markets. That cost manifested not just in the overly restrictive payout criteria but also in the high cost of administering the PEF. Over the course of its five-year lifetime, from 2016 to 2021, the insurance window of the PEF spent USD 111 million to create and manage the financial instruments (bonds and swaps) involved; costs that were covered by donor contributions of USD 117 million that could have otherwise been used to respond to the pandemic.[55] While USD 196 million from the insurance window was eventually released from private investors and spent on outbreak response, the overly restrictive payout criteria used to assuage investor concerns meant that those funds arrived too late to have had any significant effect on containment.[56]

The participation of private finance in global health also requires a supporting apparatus of fund managers, insurers and associated legal and accountancy firms who perform broker tasks like underwriting and conducting bond issuances, all of which incur substantial additional costs. For example, legal proceedings in the USA against Abraaj indicate that within 18 months of launching its Growth Health Markets Fund, Abraaj had paid itself USD 40 million in 'management fees' and expenses from the fund.[57] Such figures are not unusual in an industry where high-value transactions are accompanied by high fees.

A recent study of the IFFIm 'vaccine bonds' found that far from catalysing additional (private) funds for vaccinating children in LMICs, as is claimed by Gavi, the IFFIm in fact sees money flowing in the opposite direction. IFFIm's bonds raise funds from private investors and those funds temporarily go to Gavi, but eventually, they have to be repaid to the private investors, plus interest. The bonds offer a frontloading mechanism but at a substantial cost to Gavi and the governments whose grants are used to pay interest on the bonds, and ultimately results in a net loss in terms of funds available for vaccinating children in low-income countries. Up until 2019, about one-third of the USD 3.1 billion in donor government payments made so far to IFFIm had been extracted by financial actors predominantly located in the Global North. This diversion of public money largely comprised of USD 879 million of interest payments to bondholders and USD 55 million to the financial institutions and professional services firms contracted to help manage the complex financial and legal arrangements (this included bond issuance costs at USD 33 million, lawyers' fees at USD 10 million, auditors fees at USD 5 million, insurance indemnities at USD 4 million and consultant fees at USD 3 million).[58]

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[54] Brim B and Wenham C, 2019. Pandemic emergency financing facility: Struggling to deliver on its innovative promise. BMJ, 367
[55] World Bank, 2021. Pandemic Emergency Financing Facility Financial Report. Available from: https://fiftrustee.worldbank.org/content/dam/fif/funds/pef/TrusteeReports/PEF_TF_04_30_2021.pdf
[56] Ibid.
[57] United States District Court Southern District of New York, 2019. Securities and Exchange Commission v Abraaj Investment Management Limited, and Arif Naqvi.
[58] Hughes-McLure S and Mawdsley E, 2022. Innovative Finance for Development? Vaccine Bonds and the Hidden Costs of Financialization. Economic Geography, 98(2):1-25.

Indeed, the study's researchers argue that the large and ongoing payments to bondholders would require the IFFIm to issue new bonds just to pay off the older ones. Similar problems have emerged with PPPs used to construct and manage new healthcare facilities resulting in ballooning costs and ministries of health diverting large portions of their budgets to expensive repayment schedules. The World Bank-backed construction and operation of the Queen Mamohato Hospital in Lesotho is notorious because government payments to the private consortium that built and ran the hospital ended up consuming half the country's entire health budget, and because government debts to the private consortium grew further due to penalties and raised interest when the former could not keep up with its payments.[59] In 2021, at the height of the COVID-19 pandemic, all nurses at the hospital were sacked by the private consortium for their strike action demanding equal pay to government-employed nurses. This and other financial challenges and disputes eventually led the government to terminate the contract 5 years early,[60] reportedly at a cost to the government of USD 171 million.[61] The long-term financial ramifications for the government of Lesotho, including its outstanding debts owed to the private consortium, and the future of the hospital remain unclear. Similar instances of governments being forced to pay off private consortia have been documented in the UK,[62] Turkiye (see Case 3) and Mexico.[63]

There are also opportunity costs. The high cost of private finance (its fees, borrowing costs and spiralling repayment schedules) – results in public funds being diverted away from other activities that might be more appropriate, impactful, cost-effective and equitable. This includes initiatives that could better promote health and development (e.g. public health measures to address harmful impacts of tobacco, ultra-processed food and sugar-sweetened beverages) but which lack the same opportunities to regularise revenue generation and wealth extraction for private investors.

Case 3: Turkiye's Health Campuses.

As part of a healthcare system reform programme that began in 2003, Turkiye announced a health campus initiative in 2010. The national government planned to build 32 hospitals across the country, modernising and expanding the country's public healthcare system, with the initial cost estimated at USD 13.1 billion.[64] To fund this ambition the government opted for a PPP arrangement of the kind advocated by international institutions and used in several other countries.

To deliver the PPP, private construction consortia created 'special purpose vehicles' for each health campus to manage and channel the loans and investments from public and private investors. Multilateral and bilateral public investors led the way, giving legitimacy to the initiative and encouraging private investors to follow suit.[65] These included the European Bank for Reconstruction and Development, the World Bank's IFC, USA's International Development Finance Corporation (DFC), France's Proparco, the Korea Development Bank, Germany's DEG, the European Investment Bank, and the Japan Bank for International Cooperation.

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[59] Oxfam, 2014. A Dangerous Diversion: Will the IFC's flagship health PPP bankrupt Lesotho's Ministry of Health?
[60] Eurodad, 2022. History RePPPeated II - Why Public-Private Partnerships are not the solution
[61] Kabi P, 2021. Lesotho: Tšepong Agrees to Termination of QMMH Contract. Lesotho Times. Available from: https://allafrica.com/stories/202105120910.html
[62] Bayliss K, 2016. The financialisation of health in England: lessons from the water sector. FESSUD Working Paper Series No 131
[63] Quartucci S, 2024. Mexico Acquires Privatized Hospitals to Boost Health Infrastructure. Latina Republic, June 19. Available from: https://latinarepublic.com/2024/06/19/mexico-acquires-privatized- hospitals-to-boost-health-infrastructure/
[64] Presidency of the Republic of Turkiye Investment Office, 2019. Investing in Infrastructure & PPP projects in Turkiye.
[65] Hunter BM, 2023. Investor States: Global Health at the End of Aid. Cambridge University Press

Further encouragement for private investors came in the form of generous interest rates: according to one account, investors could expect returns of around 8%.[66] Furthermore, the promise of risk insurances from multilateral and bilateral institutions helped reassure investors who were hesitant following the attempted coup in Turkiye in 2016. National export credit agencies from South Korea and Japan, for example, provided risk insurance and credit guarantees for private investors from each country respectively. The World Bank's insurance arm MIGA also offered guarantees to private investors.

Despite high-level policy support, nationally and internationally, this infrastructure PPP initiative became increasingly unsustainable. Turkiye's protracted economic crisis through the 2010s led to significant devaluation of the lira, making it increasingly expensive for the partners in Turkiye to meet payment obligations denominated in US dollars. Several of the special purpose vehicles had to seek new financing to meet their repayment obligations, while Turkiye's Ministry of Health's payments for ten completed health campus sites swelled to more than 25% of its budget.[67] Turkiye's PPP model has been argued to be particularly poor value for money, with lease payments to consortia that are excessive, guarantee payments that limit government budget flexibility, and high average costs per bed.[68] Having become increasingly concerned by the high fees being paid to private consortia, the government announced it would no longer use the PPP model and would fund the remaining health campuses using public funds.

2.2 Changes to global health practice

The field of global health has been driven to a significant extent by principles and aspirations of humanitarianism, solidarity and justice. The fields of public health and medicine, for example, have traditionally been shaped by the impetus to provide care and alleviate suffering, with non-financial rewards playing an important role. A long tradition of public health has also emphasised the social determinants of health and the fundamental importance of reducing social inequalities in addressing disparities in health or access to healthcare. Financialisation and the expanded influence of private financial actors distort this mission by re-orienting the field towards a set of ambitions and practices that ultimately prioritise and reflect the interests of the financial services industry and its constituents.

At the international level, key global health institutions have become increasingly input-oriented, meaning they focus and limit their attention and efforts to anticipating funding needs, identifying shortfalls and finding new sources. Increasingly in global development broadly, private finance is framed as a pragmatic source of funding in spite of its high costs. In fact, private finance is often presented as the only option because it is claimed that there are no options for generating additional public finance. This mindset is reflected in the highly publicised calculation of a 'financing gap' of USD 176 billion for UHC in the world's 54 poorest countries[69] and by the assertion that private finance is necessary to fill this gap.

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[66] Ibid.
[67] WHO Regional Office for Europe, 2023. Public–private partnerships for health care infrastructure and services: policy considerations for middle-income countries in Europe
[68] Ayhan and Ustuner, 2023. Turkey's public–private partnership experience: a political economy perspective. Southeast European and Black Sea Studies, 23:1
[69] World Bank, 2019. High-Performance Health Financing for Universal Health Coverage (Vol. 2) : Driving Sustainable, Inclusive Growth in the 21st Century

International and national policymakers and technocrats are frequently encouraged to see private financial actors and the private companies in which they invest as legitimate 'partners' who should play an ever-expanding role in healthcare ownership, provision and, increasingly, financing and regulation. Meanwhile, the space for public agencies and public-interest or non-profit organisations is shrinking in many contexts. The prevailing vision for national healthcare systems, as in other social sectors,[70] has thus moved towards those forms of healthcare provision that can attract private investment. Notably, while private actors are diverse, it is specifically companies with corporate ownership structures that are of greatest interest to both the large institutional private investors and their governmental backers as they offer the best route for profit generation and for the scale of improved healthcare coverage (regardless of quality and equity concerns).

The growth of corporate healthcare providers and private financial interests with business models designed to boost surplus revenue and shareholder value by whatever means necessary has, among other things, incentivised unnecessary testing and treatment, undermined the quality and efficiency of care, expanded the imposition of user fees, led to the closure of unprofitable clinical departments regardless of need and created downward pressure on the remuneration and job security of healthcare workers.

Such trends are pronounced in the USA, where a recent systematic review of published research found that ownership of healthcare providers by a specific type of investor - private equity - was associated with increased costs for healthcare users (or insurers on their behalf) and with mixed to harmful impacts on quality of care.[71] In this context, hospital management is being governed and directed to achieve greater market power, and to meet revenue targets and strong credit ratings.[72] Even the insurance companies that finance healthcare provision in the USA have become vehicles for profit generation by private investors: the seven largest health insurers allocated USD 26.2 billion to share buybacks in 2023 alone rather than reinvesting this, for example, in improving services or reducing premiums for users.[73] India's private healthcare sector is another powerful example of similar trends (see Case 4).

Case 4: Corporate healthcare in India

In recent decades, India's private healthcare sector has become dominated by large corporate chains such as Apollo, Fortis, Max and Narayana. Emerging from an ecosystem of diverse single private facilities set up in the 1990s, the corporatised private healthcare industry grew in a context of low levels of public expenditure and chronically under- resourced public hospitals, as well as government policies explicitly designed to encourage private sector expansion (including through public subsidies and relaxing the rules around foreign investment), actively promote a medical tourism industry and encourage a medical export industry targeting foreign markets.[74] The corporatised Indian medical sector has now extended into other areas such as primary care, home-based care, diagnostics, telemedicine and even education. The transition from standalone private facilities to multi-site, multi-market and in some cases multi-national hospital chains has involved a significant shift in ownership patterns.[75]

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[70] Lavinas, 2018. The Collateralization of Social Policy under Financialized Capitalism. Development and Change, 49(2): 502–517
[71] Borsa A, Bejarno G, Ellen M and Bruch JV, 2023. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. BMJ, 382:e075244
[72] Bruch R, Roy V and Grogan CR, 2024. The Financialization of Health in the United States. New England Journal of Medicine, 390(2): 178-182
[73] Bruch R, Roy V and Grogan CR, 2024. The Financialization of Health in the United States. New England Journal of Medicine, 390(2): 178-182
[74] Chakravarthi I, Hunter B, Marathe S and Murray S, 2023. Corporatisation in Private Hospitals Sector in India: A Case Study from Maharashtra. Economic & Political Weekly, 58(11):57-64
[75] Hunter B, et al., unpublished. Financialisation and the Reshaping of Private Healthcare: A Case Study in India

Earlier periods of private hospital expansion led by founder-practitioners and based on personal savings and government loans have been superseded by the accelerated scale- up of private foreign investment. While many founder-practitioners and their families retain some shareholding, ownership has moved towards foreign, institutional investors. Multilateral and bilateral investors laid some of the groundwork for this. For example, the World Bank's IFC has invested well over USD 0.5 billion since 1997 in growing India's biggest corporate hospital chains,[76] with other DFIs following suit.[77] [78] Private equity investors have since become prominent through a series of takeovers and public listings at the leading chains.[79]

Interviews with people working in and running India's corporate hospital chains have shown how the ascent of institutional investors has embedded 3- to 7-year investment cycles within the running of hospitals.[80] Investors use large hospital revenues to meet their own immediate financial needs while building company value with a view to significant financial returns in the medium-term. Growth in value has involved some new developments, but frequently entails the quicker option of acquiring existing facilities with existing service user networks.
Once these facilities are absorbed into the chains, pressure to generate profits filters down the levels of administration. Senior managers are appointed on a profit-sharing basis or given incentives to achieve revenue targets. Hospital revenue targets are disaggregated into revenue targets for clinical departments so that decisions about new staff and equipment are based on whether the costs can be recouped through additional revenue. While senior specialists who can bring in new business are highly prized and rewarded, the junior doctors, nurses and other health professionals experience significant precarity as hospital managers look to reduce staffing costs and financial liabilities.[81]

The commercial pressures that now govern much of the healthcare system have led to wide-scale violations of users' rights by hospitals, including overcharging, denial of healthcare, price rigging and medical negligence.[82] High prices and overcharging have led to prolific health-related poverty[83] with the rate of impoverishment being 11 times higher for a private hospital than a public hospital.[84] Regulation is insufficient and fragmented across a range of public and private agencies, resulting in partial and disjointed systems of governance that fail to prioritise the needs of users.[85] Such is the scale of concern that a former Chief Justice recently spoke out against the 'profit led corporatisation' of India's healthcare.[86]

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[76] Oxfam, 2023. First, Do No Harm: Examining the Impact of the IFC's support to private healthcare in India
[77] Oxfam, 2023. Sick Development. How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped
[78] Marathe S and Shukla A, 2024. Perverse Development-Examining German Development Finance Institutions' Engagement in Private Healthcare Sector in India. Development, doi.org/10.1057/s41301-024-00408-4
[79] Chakravarthi I, Roy B, Mukhopadhyay I and Barria S, 2017. Investing in Health: Healthcare Industry in India, Economic & Political Weekly, 52(45): 50-56
[80] Hunter et al., unpublished. Financialisation and the Reshaping of Private Healthcare: A Case Study in India
[81] Marathe S, Hunter BM, Chakravarthi I et al, 2020. The impacts of corporatisation of healthcare on medical practice and professionals in Maharashtra, India. BMJ Global Health, 5:e002026
[82] Oxfam, 2023. Sick Development. How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped
[83] WHO and World Bank, 2023. Tracking Universal Health Coverage: 2023 Global Monitoring Report
[84] Sriram S and Albadrani M, 2022. Impoverishing effects of out-of-pocket healthcare expenditures in India. Journal of Family Medicine and Primary Care, Nov;11(11):7120-7128
[85] Hunter BM, Murray S, Marathe S and Chakravarthi I, 2022. Decentred regulation: The case of private healthcare in India. World Development, 155:105889
[86] Choudhary, 2022. Hosp corporatisation denies healthcare access to poor: CJI. Times of India, 24 Aug 2022. https://timesofindia.indiatimes.com/india/hosp-corporatisation-denies-healthcare-access-to-poor- cji/articleshow/93740861.cms

In the biotechnology sector, engagement by private investors is disincentivising research and development, particularly into health issues deemed unprofitable or insufficiently profitable. Leading biotechnology companies increasingly rely on an acquisition-based business model that reduces risks for their own investors. In this model, the early stages of technological development are left to smaller, often publicly subsidised, companies that can be acquired (along with their intellectual property) in the event of promising results from clinical trials.[87] The larger and more powerful acquiring company can then optimise marketing and pricing, and navigate intellectual property regimes, to maximise profits and create opportunities for further revenue extraction through cycles of share buybacks and acquisitions (see Case 5). One analysis of the largest 14 publicly-listed pharmaceutical companies in the USA found that they spent a combined total of USD 747 billion on share buybacks and dividends during the 10-year period from 2012 to 2021, USD 87 billion more than they spent on research and development during the same period (USD 660 billion).[88] Beneficiaries of this include the clients of the world's largest asset management companies who have shareholdings in many leading pharmaceutical companies, including AstraZeneca, Pfizer and Moderna, as well as the asset managers themselves.[89]

Case 5: Hepatitis C treatments

When Sofosbuvir-based medicines were launched in 2013, they marked an important breakthrough for patients with hepatitis C infection, offering cure rates of over 90% for a leading infectious killer that disproportionately affects vulnerable people. Yet manufacturer Gilead Sciences set prices - USD 90,000 for a 3-month course in the USA - that were far in excess of what many individuals and governments could afford. Industry leaders and even many health policy experts defended the prices, arguing that society should be willing to pay more for better treatments that might avert longer-term costs. But even in high-income contexts, the reality of strained public health budgets means that governments have had to ration treatment, focusing on those with advanced complications of hepatitis C.

Closer investigation of the drug development process for Sofosbuvir-based medicines raises many questions about the ethics of these high prices.[90] Crucially, Sofosbuvir-based medicines originated in publicly funded research at US-based Emory University. This research was then spun out into a venture-backed company called Pharmasset, which was in turn acquired in 2011 by Gilead Sciences for USD 11 billion. Subsequently, Gilead Sciences made USD 46 billion in revenues from sales in the first 3 years after Sofosbuvir-based medicines were launched.[91] This enabled Gilead to reward its shareholders with share buybacks totalling USD 26 billion, more than double the amount it put into further research and development processes. Meanwhile the top five executives at Gilead, substantial shareholders themselves, received over USD 1 billion in financial benefits in three years. With cash reserves in excess of USD 30 billion, the company would go on to pursue further acquisitions following a similar pattern of highly priced products and profit growth.

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[87] Roy V, 2023. Capitalizing a Cure How Finance Controls the Price and Value of Medicines. University of California Press
[88] Lazonick W and Tulum O, 2022. Sick with "shareholder value": US pharma's financialized business model during the pandemic. Competition & Change, 28(2): 251-273
[89] Camacho S, Castrejon D and Silva D, 2023. El Negocio de Las Vacuuna$: Balance post-pandemia. PODER: https://poderlatam.org/wp-content/uploads/2023/07/InformeVacunas_BalancePostPandemia.pdf
[90] Roy V, 2023. Capitalizing a Cure How Finance Controls the Price and Value of Medicines. University of California Press
[91] Ibid.

This prevailing pharmaceutical business model, which focuses on deriving profits from pharmaceutical products as financial assets at the expense of affordable and equitable access, was particularly evident during the COVID-19 pandemic. Leading pharmaceutical companies, backed by governments from high-income settings, were able to dominate markets for vaccines and other technologies and vigorously oppose calls to share these with other manufacturers to increase production and expand access more quickly. The enormous windfall profits that Moderna, Pfizer and BioNTech generated from their control of these markets and products, which in many cases could be traced back to significant public subsidies at various stages of research and clinical trials, enabled these companies to run a series of large share buyback programmes to transfer profits to shareholders.[92]

2.3 Loss of public accountability and regulatory capture

The actors and institutions of private finance operate as commercial ventures with accompanying expectations around commercial confidentiality and secrecy. Unlike public institutions, there are few public scrutiny mechanisms for private finance, and financial information may not even be available to policymakers.[93] The source of private funds and their entry into public systems and global platforms tend to be obscured by confidentiality agreements and the multi-layered, decentralised structure of financial transactions. All this poses a severe challenge to democratic governance and accountability. The lack of transparency and accountability further extends to the public institutions involved in the operations of private finance. For example, in Rio de Janeiro, a bank managing the city's public health fund denied public auditors access to information on investments, citing the primacy of 'bank secrecy'.[94]

The role of DFIs in promoting blended finance has also been marked by systemic gaps in accountability. DFIs commonly channel their funds through third-party fund managers that supposedly provide specialist knowledge and help reduce the risk of losses. Many of these fund managers are based in tax havens where they face limited requirements for financial disclosures.[95] In a recent Parliamentary inquiry, the Chief Executive at the UK government's DFI, British International Investment (BII), was frank in explaining that BII's fund managers have significant discretion over where funds are invested and noted that 'when you use any intermediary, you lose some element of control'.[96] This is a particular concern as healthcare companies receiving DFI investments are increasingly being linked to human rights abuses (see Case 6).

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[92] Wood B and Sacks G, 2023. The influence of share buybacks on ill-health and health inequity: an exploratory analysis using a socio-ecological determinants of health lens. Globalization and Health, 19(3)
[93] Stein F and Sridhar D, 2018. The financialisation of global health. Wellcome Open Res, 3:17
[94] Public Prosecutor's Office of the State of Rio de Janeiro (Ministério Público do Estado do Rio de Janeiro - MPRJ), 2018. "Avaliação de Impactos e Abertura de Dados no Planejamento e Gestão Financeira da Saúde" [Impact Assessment and Open Data in Health Planning and Financial Management]. Rio de Janeiro: MPRJ.
[95] Hunter BM and Marriott A, 2018. "Development Finance Institutions: The (in)coherence of their investments in private healthcare companies", in Reality of Aid Report 2018.
[96] House of Commons International Development Committee, 2023. Oral evidence: Investment for development: The UK's strategy towards Development Finance Institutions, HC 884,Q201

Tellingly, DFIs have mostly avoided proper evaluations of the impact of their blended finance investments, falling back instead on broad and non-specific claims about expanding access to services and creating more jobs through new private investment. For example, no health impact evaluations for lending and investments in India have been disclosed by the World Bank's IFC since the start of its healthcare operations there over 25 years ago.[97] Although BII is unusual in having a framework for evaluating the impact of its investments in health systems (it encompasses the four dimensions of quality of care, access to care, workforce, and stewardship),[98] only one evaluation using the framework is publicly available. And while it was broadly positive about the provider in terms of quality, workforce and stewardship, it raised concerns about access, noting that there seemed no way to determine if patients were incurring catastrophic medical expenses, a key measure of UHC. While BII reports having performed evaluations of other investments,[99] BiII has also explained that its framework is merely a 'soft' tool to encourage companies to move in the right direction and that it would be unrealistic to make its investments conditional upon providers implementing user fee levels that would not block access to essential healthcare.[100]

Case 6: DFIs and the human consequences of poor accountability

DFIs are partnering with private finance to invest USD billions in for-profit hospitals in LMICs. Research into the private healthcare portfolios of four European DFIs and the World Bank's IFC has identified multiple cases of alleged and confirmed abuse of patients' rights, including the detention of patients for non-payment of bills, denial of emergency treatment, the provision of unnecessary diagnostic procedures and treatments, and systemic overcharging.[101]

In two hospital chains funded by DFIs in India, patients with government health insurance cards were pushed into poverty by fees they should never have been charged. Moreover, the fee schedules of the DFI-funded hospitals indicate that hospital care would be inaccessible to most people. For example, the average starting cost for childbirth across all the DFI hospitals where fee information was available was equivalent to a year's income for an average earner in the bottom 40% of that country.

During the pandemic, multiple DFI-funded private hospitals were found to have either closed their doors to COVID-19 patients or had exploited people's desperation by charging USD thousands for ICU beds. This occurred in some of the poorest countries such as Uganda and Mozambique. Some of these hospitals even benefited from emergency aid from the World Bank's International Development Association (IDA) Private Sector Window[102], and channelled via the IFC as part of the World Bank's pandemic response.

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[97] Oxfam, 2023. First Do Harm: Examining the Impact of the IFC's support to private healthcare in India
[98] Wadge H, Roy R, Sripathy A, et al, 2017. Evaluating the impact of private providers on health and health systems. London, UK: Imperial College London.
[99] Edwards S, 2019. CDC seeks sustainable investment in private health care. Available from: https://www.devex.com/news/cdc-seeks-sustainable-investment-in-private-health-care-94122
[100] Oxfam, 2023. Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped.
[101] Oxfam, 2023. Sick Development: How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped; and Oxfam, 2023. First Do Harm: Examining the Impact of the IFC's support to private healthcare in India
[102] World Bank. What is the IDA Private Sector Window? https://ida.worldbank.org/en/financing/ida-private-sector-window/what-is-ida-private-sector-window

Accountability and regulation of these investments is lacking on multiple levels. First, there appear to be no mechanisms to hold DFIs accountable for their decisions to invest in large commercial private providers in countries where government oversight and regulations to protect patients and staff are clearly inadequate. Second, DFIs lack the mechanisms, capacity and/or the willingness to thoroughly vet or apply human rights due diligence and other social and economic impact monitoring of the corporate providers in which they invest, even in cases where there are repeated reports of abusive behaviour. Indeed, DFI staff themselves acknowledge that their influence on company behaviour is limited at best and even less so for the over 80% of health investments they make via private financial intermediaries, including private equity funds. Third, there is little public knowledge and transparency about these DFI investments. Except for BII, none of the DFIs systematically disclose their indirect healthcare investments with commercial confidentiality frequently cited as justification for non-disclosure of information about performance, impact or follow up to alleged human rights abuses. Research has also indicated that most patients, communities and legislators in the localities of DFI-funded hospitals lack information about DFI funding, making it all but impossible for people to seek accountability for any violation of human rights and other harms.

In response to mounting evidence that DFI investments in for-profit healthcare providers are widening healthcare inequalities, exacerbating poverty and deepening gender-based discrimination and violating human rights, 70 organisations have called for an end to new investments as well as a full independent investigation of previous investments and appropriate remedy for any harms identified.[103]

Effective public scrutiny is also curtailed by financial actors and institutions routinely using complex and opaque language and data. Most lay observers are also often reliant on cursory information provided in press releases and corporate disclosures, or on information that requires expert financial knowledge to interpret. In some cases, government agencies have also used complicated accounting practices to move debts off-budget in ways that obscure or downplay the debt obligations being incurred by governments while making private finance appear less expensive than more conventional forms of health funding.[104] Information on financial operations, when available, is mostly fragmented, inconsistent, and incomplete. As researchers of GAVI's IFFIm have noted, the large transfers of profit to private investors are often hidden within the complexity of the data.[105] Additionally, there are no consolidated and comprehensive databases on the volume of funds being transferred and the returns paid to investors for the various financial instruments and arrangements described in this briefing paper.

This non-transparent and unaccountable system of financing and governance is also often locked-in by agreements that can extend for decades. The commitment to pay banks and investors is often baked into legal provisions ensuring that money from taxes or public budgets will always cover the costs of payment to private investors, including the principal, interest and commissions. Repayments for bonds and infrastructure PPP arrangements can extend for up to 40 years, far more than any parliamentary term length, yet are closed off from parliamentary scrutiny.

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[103] Oxfam and Partners, 2024. Open statement: stop spending development funds on for-profit private healthcare providers. https://www.oxfam.org/en/research/open-statement-stop-spending-development-funds-profit-private-healthcare-providers
[104] Romero and Vervynckt, 2017. Unpacking the dangerous illusion of PPPs, in Kishimoto and Petitjean (Eds) Reclaiming Public Services: How cities and citizens are turning back privatisation. Transnational Institute
[105] Hughes-McLure S and Mawdsley E, 2022. Innovative Finance for Development? Vaccine Bonds and the Hidden Costs of Financialization. Economic Geography, 98(2):1-25

In some cases, global health platforms and governmental agencies end up being locked into repeated cycles of debt generation in order to maintain solvency. As noted earlier, researchers examining the complex and debt-fuelled nature of IFFIm have indicated that IFFIm must issue new bonds to make interest payments on and redeem old bonds. In Argentina, the local government of Buenos Aires issued 'debt cancellation' bonds in 2020 to settle payment arrears with private healthcare providers (and providers of other services) who had been granted the right to receive a monthly income flow (accrued with interest), thus causing the local government to replace one debt with another.[106]

Effective accountability is also challenged by the significant potential for the capture of public agents and regulatory bodies by private finance. Private financial actors are politically active and influential in the governance of states around the world, lobbying for new investment opportunities and for greater deregulation.[107] [108] Large asset managers have become especially powerful and have reportedly played a key role in undermining sustainable finance regulations in the EU. There is also a dearth of financial regulatory capacity in many countries (not just LMICs), making it easier for large private financial investors and corporate actors to resist public interest regulation that undermines their interests. And when regulation does exist, it tends to be designed to protect shareholder interests rather than to prevent fraud or promote public health.

As global health becomes increasingly dependent on politically and economically powerful private financial actors, there is likely to be more intensified lobbying for light-touch regulation and risk mitigations that may prioritise the interests of financial actors at the expense of others in society. Many of these concerns are illustrated powerfully by the case of France's social security bonds (see Case 7).

Case 7: France's social security bonds

In France, the government has been issuing bonds to reorganise a debt incurred by the social security system.[109] A public agency was created to sell bonds in foreign markets and to use the money that it raised to pay off the debts of the social security system. This essentially erases one form of public debt (the debt of the social security system) and replaces it with a new debt (the debt of the bond-issuing agency) to financial investors.

The pretext is that this new debt to investors would be less costly than the debt currently held by the social security system.[110] Additionally, international markets are considered to be an almost limitless source of potential funds with different exchange rates that might even lead to lower interest rates than those found in domestic credit markets. Thus by 2016 (the last year for which there are data on the origins of the bondholders), around 95% of the investors in the social security bonds were foreign and mostly institutions such as banks and investment funds, resulting in France's social security system being fully integrated into global financial networks and in a significant transfer of wealth from the French government to international investors.

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[106] Buenos Aires Province, "Instructivo de Bonos de Cancelación de Deuda para el acreedor". Retrieved from https://www.tesoreria.gba.gob.ar/images/contenidos/normativa/10_Bonos_BCD/acreedor/Instructivo_bonos_acreedor.pdf.
[107] Pagliari S and Young K, 2020. How Financialization is Reproduced Politically in Mader P, Mertens D and van der Zwan N (Eds), The Routledge International Handbook of Financialization. Routledge
[108] Bracking S, 2016. The Financialisation of Power: How financiers rule Africa. Routledge
[109] Cordilha AC, 2023. Public Health Systems in the Age of Financialization: Lessons from the Center and the Periphery. Brill Press
[110] Cordilha AC, 2023. Public Health Systems in the Age of Financialization: Lessons from the Center and the Periphery. Brill Press

From 1996 to 2023, the public agency in charge of the strategy took on debt worth EUR 387 billion by issuing bonds. Over the same period, it paid around EUR 92 billion in interest payments to investors and in fees to banks (figures in 2023 euros adjusted by the consumer price index). The government used public funds intended to finance social security to cover these interest payments and fees, 90% of which comes from taxation on wages, pensions, unemployment benefits, and from a public fund originally designed to help finance the pension system.

The accountability of the public system, now reliant on foreign investors, is undermined by the difficulty in knowing the identity of the international investors who hold the bonds. In 2010, the French Budget Ministry declared that: “the texts currently in force do not authorise [the identification of the bondholders] consequently, Agence France Trésor [the agency that issues France’s sovereign bonds] cannot precisely identify who are the holders of the bonds".[111] It is thus not possible to know where exactly the funds used to refinance social security came from, how much is owed to whom, nor where the interest payments end up. The French government appears to only have partial knowledge over who holds and profits from the social security bonds.

The orientation of the bonds towards international markets has also resulted in a range of other external and private financial actors becoming involved in France’s social security policy: credit rating agencies assess the bonds, affecting the number of investors they attract; national and foreign commercial banks, such as UBS and Citibank, organise these operations; and clearing agencies located in Belgium and Luxembourg (which are lower tax jurisdictions) settle the transactions.

During a recent debate in the French National Assembly, the president of the public agency responsible for issuing the social security bonds opposed the idea that part of the revenues used to pay investors back should be reassigned to fund actual frontline services which had suffered severe budget cuts as this would be “catastrophic for the image [of the bonds].”[112] The implication is that increasing spending on health at the expense of investors would negatively impact how credit rating agencies perceive the bonds, which would reduce investor demand, increase the cost of issuing future bonds and thereby constrain the ability to refinance social debt in the future.

3. Potential Responses: Building New Narratives and Accountability

The previous sections have outlined the political and economic roots of financialisation and how this helped expand corporate ownership, harmful profit-maximising forces and shareholder primacy within healthcare systems and beyond. These roots include the progressive deregulation of the financial sector and the adoption of policies and new financial instruments by governments and multilateral organisations aimed at attracting private investors into the health and development sectors.

We have described three sets of overlapping problems associated with the growing influence of private financial actors in global health: the high cost of private investment (frequently more expensive than public investment) which often amounts to the public subsidisation of private profit; the undermining of public health principles and values centred around reducing health inequities and serving the public interest; and a weakening of democratic governance and regulatory capture by powerful private financial actors.

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[111] Assemblée Nationale, 2010. Question n. 81789 de M. Gandolfi-Scheit Sauveur (UMP - Haute-Corse). Retrieved from https://questions.assemblee-nationale.fr/q13/13-81789QE.htm
[112] French National Assembly, 2024. Mission for the evaluation and control of social security financing laws, hearing of March 21, 2024.

The scale and degree of excessive profiteering and resource extraction by private financial actors who are unaccountable to the public are not just harming health and weakening the capacity of national healthcare systems to deliver equitable, effective and efficient healthcare, it is also undermining the capacity of society to govern, fund and deliver a range of public institutions, goods and services upon which broader social wellbeing and social justice is dependent. Individuals and institutions concerned with global health can challenge and reverse these harmful trends in three ways.

3.1 Challenge the common fallacies and false narratives regarding private finance

Private finance in global health is frequently promoted on the grounds that it is necessary given shortfalls in public finance and that it is cheaper, quicker or lower risk compared to public borrowing. These claims are also typically accompanied by rhetoric about the need for urgent investment, for example, to save lives or meet the SDGs. This short-termist simplification often leads to a neglect of detailed considerations about the true costs of private financing, its implications for governance and accountability and the long-term consequences of expanded privatisation and commercialisation on equity and efficiency.

This neglect of key questions is sustained by a number of key narratives that help legitimise the expanded role of private finance in global health. The narrative of win-win arrangements is perhaps the most pernicious, promoting the notion that health gains, however small or incremental, may compensate for any negative impacts on health, equity or healthcare quality that result from the financial extraction of profits. Another source of misunderstanding is the use of the term investment in a way that implies a flow of money into global health when often private financial investment is designed to create opportunities to extract profits from the health system, including through short-term asset stripping. Finally, the frequent use of the term risk management is deployed to convey the existence of appropriate and responsible governance of private investments even when in reality it often means managing financial risk in such a way as to protect private investors from a potential loss.

Concurrently narratives are also constructed by DFIs and other bodies to portray private financial actors and private companies as legitimate ‘partners’ who should play an ever-expanding role in not just healthcare ownership and provision, but also increasingly in regulation. As the space for public agencies and non-profit organisations subsequently shrinks, the environment is set for national healthcare systems, as in other social sectors,[113] to move even further towards a dependency on commercial healthcare provision and forms of investment that must generate short-term profits.

These narratives are now being contradicted by a rising number of studies and experiences across multiple social sectors and countries that demonstrate significant short, medium and long-term public and social harms associated with financialisation. As such, the current mainstream narratives about the use of private finance should be challenged and modified to stress the risks of private investment and financialisation to public services and the public good. In addition, the focus on raising an additional quantum of finance must give way to greater emphasis on the quality and nature of finance and the fact that public and private finance are not equivalent.

Proposals to use private finance solutions must demonstrate much stronger evidence of alignment with a vision of equitable and responsive health systems. Additionally, private financial instruments, including blended financing instruments, must only be used with adequate regulation and public accountability, and without ‘commercial confidentiality’ being a blanket excuse for secrecy and non-accountability. While there is a role for private finance in society, this role must be harnessed to prevent harm, especially when public funds or public risk-sharing strategies are involved.

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[113] Lavinas L, 2018. The Collateralization of Social Policy under Financialized Capitalism. Development and Change, 49(2): 502–517

Importantly, those with an interest in public health and social wellbeing must learn to grapple with the often deliberately opaque language, jargon, unspecified and false assumptions, and byzantine complexity of the financial sector and develop enough expertise to be able to engage robustly and effectively with the changes occurring in development and global health financing and to challenge them.

3.2. Press for change in public and multilateral policy and practice

Governments and multilateral organisations have a key role in protecting the health systems and marginalised communities from the effects of egregious profiteering. At the very least they should ensure proper monitoring and evaluation of the growing range and number of private investments and blended financial instruments operating in the health and development sectors and be more transparent about the inherent contradictions and risks. Similarly, public sector research funders should establish adequately resourced and independent academic research capacity to inform public policy. Such research should enable collaboration between people and groups with different expertise and different stakes across different geographies and include communities directly impacted by financialisation.

Global health professionals and advocates should also lobby those public and multilateral organisations outside the health sector that are actively encouraging, facilitating and normalising the entry and expansion of private finance across society and the use of public funds to subsidise and de-risk this entry and expansion. These include the World Bank Group, as well as certain bilateral DFIs and private foundations. Crucially there is a case for normative arguments to reassert the primacy of democratic and accountable governance in these organisations.

In some circumstances, public institutions should withdraw support entirely from blended finance instruments and the subsidising of private finance. Healthcare provision should be one such area. DFIs have failed to demonstrate that the benefits of their investments in private healthcare provision outweigh the harms. At the very least, arms-length investment management and the use of commercial sensitivity clauses should be considered untenable when companies receiving public funds are linked to abusive and unethical behaviour. In other circumstances where private financial investment is appropriate and beneficial, public institutions must ensure adequate regulation and transparency and the adoption of legally enforceable standards and reporting systems as well as greater use of public disclosures and publicly accessible databases to make it easier for public and civil society stakeholders to follow the money and scrutinise the transfer of wealth taking place.

Historically, governments have restricted foreign ownership in sectors of strategic national importance, including healthcare, and there is a growing case to reintroduce such restrictions to limit financial speculation in these sectors. Other interventions that could help deter harmful effects or unethical practices include ensuring that profits made by private investors are effectively and appropriately taxed, using competition law to block the emergence of monopolies and oligopolies, capping profits, restricting debt-financed buy-outs, removing tax deductibility for interest payments, and reforming corporate law in such a way as to shift corporate behaviour away from shareholder primacy.[114] [115]

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[114] Appelbaum E and Batt R, 2014. Private equity at work: when Wall Street manages Main Street. Russell Sage Foundation.
[115] Balanced Economy Project, 2022. Report: Large firms making excessive profits in children's social care; CMA ducks the challenge. Available from: https://www.balancedeconomy.net/wp-content/uploads/2022/03/Children-Social-Care-Report-2022-FINAL2.pdf

In this, the global health community can be part of a wider push to restrict financialisation, together with other public-interest actors in other sectors including social care, water, residential housing,[116] farmland[117] and the production and supply of staple foods.[118] Paradoxically, the USA has become an important frontier for the regulation of private finance in healthcare. In recent years, several US state-level legislatures have proposed measures in response to concerns about profiteering, abusive behaviour, declining quality of care and deteriorating employment conditions for health professionals. These include enhanced monitoring and, in some cases, blocking private equity investments and/or limiting market consolidation through scrutiny of mergers and acquisitions.[119] At the federal level, the Senate Budget Committee launched a data-gathering exercise on these issues in 2023, followed by the launch in early 2024 of a cross-government inquiry on the 'impact of corporate greed in health care', headed by the Federal Trade Commission, the Department of Justice and the Department of Health and Human Services.[120] These efforts are encountering substantial resistance from parts of the domestic healthcare and investment industry[121] but nonetheless offer inspiration for responding to similar trends unfolding in other settings.

The WHO should also play a more prominent role in shaping policy and practice by producing information about the risks of private finance, providing guidelines on the policy options for deterring harmful and unethical practices and highlighting alternative approaches and models of financing (see below). The WHO should also call for greater policy research in this area, especially concerning regulatory gaps and opportunities, and for the education and training of relevant policymakers. It should leverage its mandate to voice concerns about excessive and unregulated financialisation in multilateral fora and negotiations and ensure that it is itself protected from the undue influence of private financial and corporate actors.[122]

3.3. Advocate for alternative models of financing and governance

The current excessive reliance on private financing is in part due to perceived constraints on public finance. Addressing the problems of financialisation must thus include making the case for alternatives to private finance and showing how such efforts are more likely to achieve the goals of sustainable development than reliance on private finance.

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[116] Gabor D and Kohl S, 2022. The Financialization of Housing in Europe: "My Home is an Asset Class". The Greens/EFA in the European Parliament.
[117] IPES-Food, 2024. Land Squeeze: What is driving unprecedented pressures on global farmland and what can be done to achieve equitable access to land?
[118] Ghosh J, Heintz J and Pollin R, 2012. Speculation on commodities futures markets and destabilization of global food prices: exploring the connections. International Journal of Health Services, 42(3), 465-483.
119] McCalmon BK, 2024. Health Care Transactions Facing Increased Federal and State Regulatory Scrutiny. The National Law Review, 2 July. Available from: https://natlawreview.com/article/health-care- transactions-facing-increased-federal-and-state-regulatory-scrutiny
[120] Federal Trade Commission, 2024. Federal Trade Commission, the Department of Justice and the Department of Health and Human Services Launch Cross-Government Inquiry on Impact of Corporate Greed in Health Care. Available from: https://www.ftc.gov/news-events/news/press- releases/2024/03/federal-trade-commission-department-justice-department-health-human-services- launch-cross-government
[121] Hwang K, 2024. Big California health care businesses win exemptions from proposed hedge fund rules. CalMatters. Available from: https://calmatters.org/health/2024/08/private-equity-health-care/
[122] World Health Organization, 2018. Framework of Engagement with Non-State Actors.

Significant public financial infrastructure already exists for development purposes. However, it is frequently under-resourced and thus unable to fulfil key mandates. Governments in high-income countries can recapitalise and reinvigorate the mandates of development agencies and reform and reimagine the role of DFIs to reduce reliance on blended financing. National development banks and sovereign wealth funds can also be tasked to prioritise social development objectives and empower government social sector ministries to champion public services and local needs, including through re-municipalisation and nationalisation initiatives. Though we have not reviewed them here, there are many contexts and instances where governments, politicians and civil society have pursued alternative pathways that avoid the perils of private finance and which can offer lessons for future policy.

It is not possible to discuss macro-economic and fiscal policy in any detail here. However, it is imperative that the global health community works in tandem with wider networks of individuals and organisations with relevant expertise to make the case for fairer social, political and economic systems. The twin objectives of debt justice and tax justice provide a basis for re-making the global financial system, correcting the current overall imbalance between private and public wealth, and enabling countries to reduce their dependence on private finance. The sovereign debt crises engulfing many countries, precipitated by the COVID-19 pandemic but reflecting long-standing unequal exchanges in trade and investment, are preventing governments from funding key areas of social development. Debt reductions and cancellations, by public and private lenders, are thus crucial for freeing up the resources needed to promote health.

Improved tax policies and systems provide a route for revenue generation that can be used to capitalise public bodies. This can include progressive income and wealth taxes for individuals and appropriate levels of corporation tax, as well as reforms to prevent tax evasion and avoidance.[123] It can also include industry-specific levies targeting industries that cause the greatest social and economic harms, including tobacco, ultra-processed food and sugar-sweetened beverages, fossil fuels and aviation industries. In addition to raising revenues, tax policy can deliver other important dividends including curtailing the supply and use of health-harming products, lowering carbon emissions, and reducing economic inequality. Given the scale of harm caused by the private finance industry and its investments, there is a case for substantially higher rates of taxation on this industry too. This will require greater cooperation between governments, given the mobility of private finance and the common use of tax havens. The Global South-initiated UN Tax Convention should be fully supported as an appropriate forum for building consensus and minimum global standards on all of this.

We end by agreeing with global health commentators who point to private finance as a vast reservoir of funds that could be tapped for social and public benefit. Where we differ is in how those resources should be governed and deployed. The global health community appears to have naively endorsed a process of financialisation and commercialisation that is often unregulated, and often harmful and open to abusive rent-seeking. Instead, accessing the funds of private finance should rather focus on an expanded role for wealth redistribution and public finance, and the global health community defending long-held values of public service, inclusion and accountability.

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[123] Wilkinson R and Pickett K, 2009. The Spirit Level: Why Equality it Better for Everyone. Penguin

Glossary of financial terms

Activist investors are shareholders who seek to influence company strategy. They often do so because they deem a company capable of generating greater levels of profit and shareholder value. In some cases, activist investors have social goals such as reducing a company's carbon emissions and other polluting activities. A recent study examining ultra-processed food corporations suggests that activist investors focusing on shareholder value play a larger role than those focusing on ethical concerns.[124] To exert influence, activist shareholders may organise meetings with company decision-makers, influence shareholder resolutions or join the company's board of directors. Activist investors that own or manage a large percentage of company shares will have greater influence over company strategy.

Accountancy firms are key actors in the financial sector. They are hired by private companies to compile, audit and publish the company's financial records. Accountancy firms also provide tax and legal advice, and consult on corporate finance and business strategy. The auditing of financial records should be conducted by an auditor with no financial interest in the company being audited. However, in the case of the collapsed private equity firm Abraaj Group, its accounts had been audited and approved by KPMG, which also had other interests and close ties with Abraaj. KPMG's auditing was subsequently found to have been inadequate, allowing Abraaj to continue defrauding investors until one of them uncovered the fraud. KPMG has since been ordered to pay USD 231 million to the Abraaj fund's defrauded investors.

Asset management companies are a group of financial actors tasked with overseeing and augmenting the wealth of their clients, which can include individual and institutional investors. By pooling the resources of multiple clients, they are able to invest in a wide range of financial products including company equities and bonds. They are often understood as 'passive' investors who maintain minority shareholdings (usually less than 10%) in publicly listed companies and who do not attempt to participate in company management. However, the distributed nature of share ownership for publicly listed companies means that even these relatively small shareholdings result in asset management companies being the largest single shareholders. This, and the immense resources and influence they command, means they are capable of functioning as activist investors where opportunity arises (see Case one). The 'Big Three' asset management companies are US-based BlackRock (USD 8.6 trillion assets under management), Vanguard (USD 7.3 trillion) and State Street (USD 3.5 trillion),[125] and as of 2021 together owned an average of 22% of the shares for the largest 500 listed companies in the USA.[126] Many commercial banks and investment banks also offer asset management services.

Blended finance designates the strategic use of public funds to attract additional investment by the private sector. It has been part of a wider search for innovative finance. Global health has long been a testing ground for blended finance instruments. Here, some of the first development bonds were brought to market in 2006, with the creation of the International Finance Facility for Immunisation (IFFIm). Another form of blended finance mechanism is 'matching funds', in which private sector donations are matched by contributions from public donors. Lastly, subsidies known as advanced market commitments – donor pledges to buy future commodities with public finance – were first implemented in global health and have been used to finance vaccine development. The creation of blended finance instruments in global health is driven by development banks, private foundations, public-private partnerships, and business-friendly policy-makers.

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[124] Wood B, Robinson E, Baker P et al, 2023. What is the purpose of ultra-processed food? An exploratory analysis of the financialisation of ultra-processed food corporations and implications for public health. Globalization and Health, 19(85)
[125] Thinking Ahead Institute, 2023. The World's Largest 500 Asset Managers. Available from: https://www.thinkingaheadinstitute.org/content/uploads/2023/10/PI-500-2023-1.pdf
[126] Bebchuk LA and Hirst S, 2022. Big Three Power, and Why it Matters. Harvard Law School Forum on Corporate Governance. Available from: https://corpgov.law.harvard.edu/2022/12/13/big-three-power-and-why-it-matters/

Bonds are issued by an entity as a way to borrow money. Once they have been issued, investors can buy the right to hold the bonds for a pre-determined period (the 'term'), which can last from a few months to several decades the exception to this rule are 'perpetual bonds' that have no maturity date). During the 'term', bondholders usually receive pre-defined interest payments ('coupon') at regular intervals. At the end of the term, bonds come to 'maturity' and bondholders return them to the issuing entity at which point they get back the initially paid bond price (the 'principal'). Bonds can be issued by companies ('corporate bonds'), cities ('municipal bonds'), national governments ('sovereign bonds') and multilateral development banks like the World Bank ('quasi-sovereign' bonds). In the health sector, bonds have long been used to fund the building of hospitals and more recently to help fund investments in pandemic preparedness.

Catastrophe bonds are issued as a way to borrow money in case a pre-specified disaster may break out. If the disaster occurs during the term of the bonds, issuers can use the bond price (the 'principal') for disaster response instead of paying it back to bondholders when the bonds come to term. Because bondholders risk losing the principle, they tend to receive a higher interest rate ('coupon'). For bondholders, a catastrophe bond is a potentially lucrative gamble on a disaster not taking place. For the bond-issuers it is a way to have funds on standby in case a disaster does take place. The World Bank's Pandemic Emergency Financing Facility (PEF) issued catastrophe bonds.

Commercial banks typically manage customer savings and credit, while providing a source of finance for small borrowers and businesses. In some contexts, commercial banks may also have investment banking divisions, blurring the line between these two types of banks. However, many countries require some degree of separation between the two, mainly to protect commercial bank deposits from the riskier investments of investment banks.

Consultancy firms are contracted by clients (which may include corporations, governments, inter-governmental organisations and civil society organisations) to advise on or facilitate organisational change processes or with organisational strategy. There are three widely acknowledged 'big' global consultancy firms: McKinsey, Boston Consulting Group and Bain. They also overlap with some accountancy firms that also provide organisational strategy services, including the 'big four' global accountancy firms: KPMG, Ernst and Young, Deloitte and PriceWaterhouseCoopers. Historically they have spread market-friendly ideas in governance circles, such as 'new public management'. Their influence on global health and development is widespread and includes working with WHO, regional development banks, private foundations and most large corporations in the health sector.

Credit rating agencies (CRAs) provide indicators of the creditworthiness of borrowers, i.e. the likelihood of a borrower repaying its debts on time and in full. They do so by using quantitative information about the debt and income circumstances of the borrower and qualitative information about their business and industry prospects.[127] A good rating score is a statement of confidence in a company or government repaying its creditors and lowering their borrowing costs as they are seen as lower risk. A poor score (especially those in the lowest so-called 'junk' categories) is a signal that the borrower is more likely to default and leads to higher borrowing costs. Governments and companies pay close attention to their ratings, while investors can consider ratings as part of their decision-making processes. The 'big three' (Company A, Standard and Poor – S&P, and Company B) hold significant influence within the field of CRAs. CRAs have continuously downgraded Gavi's financing mechanism IFFIm, making it more and more expensive for it to borrow money.

Debt and equity instruments. Broadly speaking, financial instruments can be classified according to the type of claims they give to their holders. Debt instruments give their holders (usually understood as the entity that is owed the debt) the right to receive interest payments and a future return of their investments. They include loans and bonds. Equity instruments give holders the right to receive monetary amounts based on the earnings of the entity that issued them, as well as the right to influence the company, something that activist investors pursue. They include shares and private equity. A company's equity is the value of its assets minus its liabilities, i.e. the money that would be left over if the company were to sell all its assets and pay off all its

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[127] Sinclair, T, 2005. The New Masters of Capital. Cornell University Press.

debts. Rather than invest in product research and development, investors may prefer paying dividends to themselves, or 'buying back' previously issued shares to keep share prices high.

Debt-to-health agreements allow indebted countries to stop servicing a debt, or reduce payments, if they redirect some of those debt payments towards domestic health expenditure instead. These agreements can be seen as a form of debt relief. The Spanish and German governments are two creditors that have signed debt-to-health agreements in recent years. The Global Fund has a Debt2Health initiative in which it operates as an intermediary in charge of agreement facilitation and monitoring.
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Development banks have been established to provide countries with long-term financing for industrial development and can exist on a national, regional or international scale. National development banks include the China Development Bank and Brazil's Banco Nacional de Desenvolvimento Econômico e Social (BNDES). Regional development banks include the Inter-American Development Bank and the Asian Development Bank. On a global level, the Bretton Woods System established the International Bank for Reconstruction and Development, which later became part of the World Bank. In recent decades some national and most multilateral development banks have begun investing in health, mainly in private-sector healthcare provision. Today the World Bank and some other development banks exert a great amount of influence over the design of health financing systems and health policy.

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Development finance institutions (DFIs) are specialised development organisations set up to support the private sector in developing countries. They provide preferential finance and expertise to private companies, to enable them and the countries in which they operate to modernise and grow. The World Bank's International Finance Corporation (IFC) is the largest DFI, but many governments of high-income economies have their own. Some DFI's are owned by governments (e.g. Germany's Deutsche Investitions und Entwicklungsgesellschaft) while others are jointly owned with private investors (e.g. France's Proparco). Their investments are not always categorised as development aid but they are powerful global health actors. For example, over the past 25 years, the IFC has invested over USD 9 billion in private health in developing countries.

Hedge funds are mutual funds that seek profit in a wide variety of markets and asset classes. Originally, they aimed to protect ('hedge against') general market fluctuations. Today, they often engage in highly speculative investment practices, including 'short-selling' (betting against the current value of companies). Hedge funds are known for their aggressive use of 'leverage' (money borrowed for investment purposes), which pushes them to render acquisitions profitable in the medium to short term. Through their investments in strategically important private companies, they can gain control over privatised parts of public health and social care systems, such as when US hedge fund H/2 Capital Partners gained control over the UK's largest elderly care provider Four Seasons in 2018, which housed 17k residents across 343 homes.

Innovative finance is a term for all new financing modalities that aim to increase development funding and make it more stable and predictable, without thereby increasing development aid. The term is used to include proposals for improved public financing such as targeted international taxation or using the International Monetary Fund's (IMF's) reserve assets for development purposes. With the UN Millennium Declaration of the year 2000, the search for innovative financing mechanisms gathered steam. During the Third International Conference on Financing for Development in Addis Abba in 2015, blended financing instruments, that rely on the private sector to close development financing gaps, have become a more popular form of innovative finance.

Institutional investor is an umbrella term to refer to companies that manage and pool the wealth of clients, making investments in a range of financial products. The term refers to a wide range of institutional types, including mutual funds, pension funds, commercial banks, investment banks, development banks and insurance companies. They are distinguished from 'retail investors' who consist of individuals investing their own money. Their larger size and resources compared to retail investors afford institutional investors a greater capacity to research and accumulate knowledge to inform investment decision-making.

Insurance companies pool financial contributions from several clients to create a fund that can be used to compensate those who are struck by an adverse event. In order to be solvent and profitable, they rely on actuaries to calculate the risk of adverse events (and therefore payouts to their insured clients) and the price of member contributions. Insurance companies may be state-owned or private. Larger insurance companies offer different insurance products across multiple sectors, including health and may also have their own investment banking arms. In the health sector, insurance companies may insure individuals against sudden healthcare costs, health technology companies against product failures, and investors in private hospitals against investment risk. For example, the COVID-19 response platform COVAX included a USD 150 million insurance for vaccine manufacturers, managed by private insurance companies.[128]The World Bank's Multilateral Investment Guarantee Agency (MIGA) insures investors in the construction of wastewater treatment plants and seawater desalination.

Investment banks typically facilitate and advise on large financial transactions for institutional clients. They help private companies, public and multilateral organisations with: conducting mergers and acquisitions, issuing bonds and stocks, underwriting, and asset management and trading. Sometimes they also invest on behalf of their clients. For example, Goldman Sachs, one of the world's largest investment banks, worked with the Bill and Melinda Gates Foundation and the British government to establish the International Financing Facility for Immunization (IFFIm) that funds Gavi and CEPI.

Loans are a form of debt in which a borrower obtains money from a lender and then repays the lender, either incrementally over time or in full at a specified end date. In return, lenders receive an interest, which either remains constant throughout the loan ('fixed' interest) or changes over time ('floating' interest).

Loan buy-downs are payments that help indebted entities (often national governments) reduce outstanding interest payments. In global health, they tend to involve three parties: lenders, borrowers and donors. Typically, donors pay off part of a country's national debt on the condition that the country engages in health reforms or achieves measurable health results. For example, in 2022 when the World Bank provided a USD 300 million loan to the government of Indonesia to fight tuberculosis, the Global Fund made USD 20 million available to reduce the repayment obligations on the loan. The Global Fund's buy-down for the loan is conditional on independently verified achievement of 'disbursement linked indicators' set by the World Bank, relating to strengthening the subnational response to tuberculosis, strengthening care from by public and private providers, and enhancing the collection and use of data. Buy-downs are similar to debt-to-health agreements.

Mutual funds pool investor money to "mutually" buy stocks, bonds, and other kinds of assets. Invented over 100 years ago, they have enabled middle-class investors to buy into diversified stock portfolios. Traditionally mutual funds include money managers, who invest for a fee. The world's largest provider of mutual funds is the American Vanguard Group. It manages over USD 9 trillion in assets, i.e. more than twice the GDP of Germany.

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Pension funds exist to provide a source of income for individuals during retirement. They receive contributions from individuals, employers and/or governments, often via payroll deductions, which they then invest in stocks, bonds, real estate and other assets. Depending on the country and legal context, a pension fund may be run by managers who are employed by the fund itself, by a separate financial services company, or by a 'trustee' entity. As part of social security systems, pension funds influence the health of pensioners around the world. At the same time, they expose large parts of the world's populations to financial risk. The largest pension funds, such as those of Norway and Japan are worth over USD 1.5 trillion each. Pension funds may invest in health. For example, the pension fund of the Dutch government Pensioenfonds ABP and Dutch private pension fund Achmea both invested in the private equity fund Investment Fund for Health in Africa (IFHA). IFHA in turn finances small- to medium-sized healthcare companies in Africa.

Private equity is a term used to describe a type of investor that usually buys shares of private companies i.e. of companies not listed on stock markets. They do so either to partake in future company earnings or to sell the shares later at a profit. PE investors often use large amounts of borrowed money to make these purchases. This 'leverage' provides them with much greater purchasing power than they would otherwise have. However, their resulting indebtedness means that PE investors will exert greater pressure on the companies they acquire to become profitable in the short term. While PE acquisition is meant to improve corporate management, a recent study of 51 PE-acquired US hospitals shows that their quality declined potentially due to profitability pressures.[129]

Public-private partnerships (PPPs) are agreements that divide costs, risks and decision-making power between public and private actors to provide a public service.[130]They have recently become a dominant institutional form in the financing and implementation of large-scale infrastructure projects, including the construction and running of public hospitals. PPPs typically involve governments providing guarantees to private investors to cover risks associated with revenue shortfalls, demand fluctuations, or regulatory change. Private investors provide loans, while a suite of private construction and service companies are engaged to build and maintain the infrastructure. In the past decades, PPPs have also become a dominant mode of multilateral health governance, following the creation of Gavi, the Global Fund and CEPI.

Regulation of the financial industry is generally geared towards ensuring competitive markets and protecting against fraud. The US government's Securities and Exchange Commission is perhaps the best-known example of a financial regulator internationally. In some settings, there are sector-specific regulators that govern national markets for certain (often consumer-facing) industries such as commercial banking and insurance. In the EU, the establishment of a common regulatory framework for the insurance sector has been accused of prioritising the stability and profitability of large private financial institutions over consumer protection. [131]

Reinsurance companies enter into agreements with insurance companies to compensate them in the event of a large-scale destructive event. Insurance companies thereby transfer some of their risk to reinsurers. Reinsurance tends to include catastrophe management, often involving risk-modelling firms to assess the risk of hurricanes, floodings or large fires. Some of the largest reinsurance companies such as Munich Re and Swiss Re have tens of billions of assets under management, so they are also important global investors. Reinsurance companies were involved in creating the terms and conditions of the World Bank's PEF.

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[130] Romero MJ and van Waeyenberge E, 2020. Beyond typologies: What is a public-private partnership?", in Gideon J and Unterhalter E (Eds.) Critical Reflections on Public Private Partnerships. Routledge
[131] Abecassis P and Coutinet N, 2021. An Increasing Homogenisation of Private Health Insurers Under Solvency II?, in Benoit C, del Sol M and Martin P (Eds), Private Health Insurance and the European Union. Palgrave Macmillan

Shares are a form of equity that may be issued to investors in return for funds, or be given to employees as a form of labour compensation. Larger companies can become listed on a stock market, thereby allowing shares to be bought and sold by a wider range of investors. Such 'public' listings create additional reporting requirements. The process of becoming listed on a stock market is referred to as an 'initial public offering' (IPO) or 'going public' while the reverse process is referred to as 'going private'. In 2015, Indian hospital chain Narayana Hrudayalaya received USD 48 million in investment from the UK DFI British International Investment (then called CDC Group) as a co-investment alongside a private equity company. It was listed a year later with its shares jumping 35% in value.

Share buybacks (also known as share repurchases) involve a company 'buying back' shares from its shareholders, usually at a high price so that the shareholders make a profit. Thus, this is a mechanism through which companies that have accumulated substantial profits and grown their cash reserves can transfer some of this wealth to their shareholders. The company can then also opt to cancel the shares that it buys back, reducing the overall number of shares for the company and thereby increasing the value of the shares that remain. This further rewards the shareholders who hold those remaining shares.

Social impact bonds (SIBs) or development impact bonds (DIBs) These are bonds usually issued by government or philanthropic entities as a means of borrowing money for social services. The share of the bond price ('principal) and/or the interest payments ('coupon') is made dependent upon whether the services they finance meet pre-defined social impacts or outcomes. The greater the success of the services, the more the government (the issuing entity) pays back to the investor. Frequently, SIBs involve a third party who is contracted to deliver the services. For example, as part of the Cameroon Cataract Bond project, three private foundations (the Conrad Hilton Foundation, the Fred Hollows Foundation and the NGO Sightsavers) financed the construction of a hospital in Cameroon to reduce blindness and vision impairment. They issued USD 2 million in bonds to social investors. The bond coupon depended on the performance of the hospital, judged in terms of eye surgery numbers and quality, as well as hospital profitability.

Sovereign wealth funds are state-owned asset management institutions. They were initially envisaged to manage the wealth accumulated by oil-exporting nations but are now used by any country with a budgetary surplus or large foreign-exchange reserves. The largest sovereign wealth funds belong to governments in Norway, China and the United Arab Emirates. Similar to pension funds, they invest broadly, with a view to securing and enhancing their value in the longer-term. In Malaysia, the government's Khazanah Nasional was until recently the largest shareholder of the multinational hospital chain IHH, which has 83 hospitals in 10 countries. Abu Dhabi's Mubadala Investment Company owns the Mubadala chain of private healthcare facilities across countries of the Middle East.

Standard-setting bodies create rules about investor practices. some specific to sectors and others more general. Industries across the USA must adhere to accounting standards set by the Financial Accounting Standards Board. Internationally, the OECD and UNDP have produced best practice standards and self-assessment tools for investors who aspire to have development impacts. They set out four main areas to integrate ideas from the SDGs into investment-making: strategy, management, transparency and governance. A major problem of international investment standards is that they are often voluntary.

Stock markets were created to facilitate trading in financial products. They now operate as privately owned companies with their own shareholders. Stock exchanges typically demand a higher level of disclosure than national company registers, on the grounds that this will enable investors to take better trading decisions. Disclosure includes quarterly finance reports, profit and loss statements, and assessments of business prospects. Companies that list shares on a stock market submit to this additional degree of scrutiny in return for the influx in capital that a listing offers and an anticipated boost to share price. The process of listing often entails publication of a brochure with company financial details and strategy.

Swaps refer to contracts between two parties who agree to 'swap' cash flows or liabilities from a financial product. This is done to 'hedge' (ie. reduce) against known risks. For example, interest rate swaps can be used to hedge against changes in interest rates and the impacts these have on debt repayments: Party A, which is paying interest on a loan at a floating rate (ie. the interest rate goes up or down) and Party B, which is paying interest on a loan at a fixed rate agree to 'swap' interest payments on the basis that either party might benefit, depending on whether the floating rate goes up or down. In this scenario, Party A is hedging against interest rate rises while Party B would benefit from a fall in interest rate. The PEF included a swap instrument to appeal to potential investors interested in 'swap' products: USD 105 million of the 'insurance window' was raised through swaps signed with parties who agreed to pay out in the event of a pandemic.

Venture capital (VC) companies are private equity investors that focus on high-risk and often relatively new companies that promise fast growth and the potential for high reward. VCs such as Adjuvant Capital receive corporate, philanthropic and multilateral support to invest in companies that develop medical technologies targeting people in lower income settings.

Vulture fund is a term used to refer to hedge funds or private equity funds that purchase debts owed by struggling companies or governments at a heavily discounted price. The vulture fund then attempts to aggressively recoup the debt in full, for example through legal action. Such funds have attained international notoriety for instigating litigation against national governments experiencing financial crises including Argentina, Democratic Republic of Congo, and Zambia.

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ABOUT UNU-IIGH

The UNU International Institute for Global Health (UNU-IIGH) in Kuala Lumpur, Malaysia, operates as the designated UN think tank specialising in global health. With a mandate to facilitate the translation of research evidence into policies and tangible actions, UNU-IIGH serves as a hub connecting UN member states, academia, agencies, and programmes.

Established through a statute adopted by the United Nations University Council in December 2005, the institute plays a pivotal role in addressing inequalities in global health. UNU-IIGH contributes to the formulation, implementation, and assessment of health programmes.

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