Économie et institutions

30-31 | 2022
Dynamiques du capitalisme sanitaire

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Ana Carolina Cordilha

Electronic version
URL: https://journals.openedition.org/ei/7418
DOI: 10.4000/ei.7418
ISSN: 2553-1891

Publisher
Association Économie et Institutions

Electronic reference
Ana Carolina Cordilha, "Financialisation and Public Health Systems: a new concept to examine ongoing reforms", *Économie et institutions* [Online], 30-31 | 2022, Online since 01 September 2022, connection on 05 November 2022. URL: http://journals.openedition.org/ei/7418 ; DOI: https://doi.org/10.4000/ei.7418

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Introduction

1 A health system comprises the ensemble of institutions, resources, and people involved in the financing, organisation, and delivery of health services at the national level (WHO, 2010). Every country has a health system, which reflects its history, its economic development, and its dominant political ideology (Roemer, 1993). The recognition of health care as a fundamental right led several countries to establish public health systems (PHS). In this work, we refer to PHS as those systems managed by the government or public entities, inscribed in the legislation, and defining access to services as a citizen right. These systems operate according to redistributive and solidarity principles, commit to providing or covering services at all levels of complexity, and cover the majority or the country's entire population. PHS can be found in several rich and emerging countries under different institutional arrangements. These include notably systems of the "national service" type, as in England and Brazil, and the "social insurance" type, as in Germany, France, and Taiwan (Rothgang et al., 2010; Giovanella et al., 2012). The importance of PHS also transcends national frontiers, to the extent that they serve as a blueprint for countries still in the quest for universalizing and expanding public provision.

2 The evolution of PHS is closely linked to the path of economic development followed by capitalist economies (Batifoulier and Touzé, 2000). The systematic involvement of public powers in the provision of health policies since the 19th century came to a great extent due to the impacts of industrialisation, urbanisation, and the organisation of working classes (Valin and Meslé, 2006). Although the historical period in which these changes unfolded in central and peripheral countries was different, such forces also

played a role in the organisation of health policies in the latter (Lobato and Giovanella, 2012).

3 The connection between changes in public health policies and capitalism became clear in the late 20th century with the emergence of an economic and political paradigm known as "neoliberalism". This paradigm has pushed for significant changes in PHS and continues to do so. These changes have been examined through an array of concepts such as *privatisation* and *commodification*. More recently, these systems have been undergoing shifts distinctive whose specificities require other analytical tools. Financialisation is a relatively new concept that has been increasingly employed to examine developments in neoliberal capitalism related to the rampant expansion of the financial sector over other dimensions. Despite clear indications that this process is also shaping developments in PHS, the mechanisms through which this occurs remain poorly investigated.

4 This article interrogates how we could incorporate the concept of financialisation into the current framework employed for assessing PHS reforms. We seek answers to two central and still open questions: One, what does it mean to say that a PHS is undergoing a process of financialisation? Two, how does this process relate to established concepts in the field? We attempt to answer these questions by drawing insights from both theory and practice: on the one hand, we review scholarly contributions to both health system reforms and financialisation; on the other, we look at examples of transformations in the public health activities of several countries that can be particularly well explained using the concept of financialisation. As an unexplored research field, we do not aim at providing conclusive findings but rather to organize a preliminary debate for further investigation.

5 Our discussion is organized as follows: first, we systematize some of the most common types of reforms in PHS over the late 20th century by describing the dominant features of privatisation, the most widely used concept in the field. Second, we introduce the concept of financialisation and suggest how it could be applied to examine recent shifts in PHS. Third, we discuss why the process of financialisation would constitute a specific form of PHS change. Using the term privatisation as a reference for more traditional forms of PHS change, we explore similarities, differences, and relations between these two processes. This discussion can contribute to a clearer understanding of the drivers, characteristics, and impacts of the present-day reforms in PHS.

I. The conventional view on PHS change: exploring the concept of privatisation

6 The 1980s marked a distinctive phase for PHS associated with the rise of neoliberalism. Among its features, this paradigm favours a particular form of State intervention directed towards protecting private ownership and profits.[1] On the one hand, the growth of public revenues was constrained by factors such as lower levels of taxation on private capital; on the other, public expenditures were rising continuously, especially in health care. Such a context brought significant changes to PHS. Governments in different countries started implementing reforms that steered them in similar directions. These include the spread of a private sector *rationale* within the

public sector, the greater participation of private actors in public provision, and the shifting of costs onto private insurers and individuals (André et al., 2015).

7 Although general trends are clear, each country presents a unique path of transformation shaped by its political, economic, and institutional context. Researchers on PHS change have employed different concepts to deal with the varied types of reforms. A cumulative reading of studies suggests that some terms are used with greater frequency to describe national experiences, such as *privatisation, commercialisation, commodification, economisation,* and *marketisation* (Cordilha, 2020).[2] This set of concepts constitutes the conventional conceptual framework of PHS research up to the present day.

8 In order to explain the particularities of the present phase of PHS reforms and why the concept of *financialisation* can help to examine them better, it is necessary to clarify to what extent recent developments differ from previous ones. In the following paragraphs, we feature earlier phases of PHS change by presenting the stylized facts associated with privatisation, the most widespread term in the field.[3]

9 The strict definition of privatisation refers to the total transfer from public to private ownership. However, this definition has little applicability in the health sector, where such experiences have been rare (André et al., 2015). In PHS research, the term usually comes with a broad meaning, comprising different changes taking place in and out of the public system. One of the ideas associated with privatisation is the adoption of languages, principles, and methods typically seen in private companies by public actors. Another is the delegation or partial transfer of public ownership, financing, management, or provision of public health care services to private actors (Mercille and Murphy, 2017; Starr, 1998). Examples of measures associated with privatisation broadly conceived include the introduction of market relations between purchasers and providers of public services, the outsourcing of public practice to private providers, the authorisation of private practice in public hospitals, and the decrease in the extension of public coverage (André and Hermann, 2012; André et al., 2015).

10 As previously noted, governments started being confronted with increasing imbalances between revenues and expenditures by the late 20th century. The chief justifications for introducing private practices, actors, and the logic of competition in PHS during the 1980s and 1990s were that such measures would reduce costs and increase efficiency in the public sector, improving public finances. Other arguments in favour of privatisation included enhancing service quality and consumer choice. Meanwhile, PHS were portrayed as inefficient and overspending, providing further ideological support to the reforms (André and Hermann, 2009; Bayliss, 2016; Frangakis and Huffschmid, 2009; Maarse, 2006).

11 The claim for privatisation was based on the assumption that private initiative is less costly and more efficient than the public sector. The theoretical basis for these claims derives from a combination of ideas from different neoclassical theories, such as the theory of property rights and the theory of the firm. Such theories argue that profit motive, competition, and ownership rights always lead to the most efficient outcomes, including in the public sector (Bayliss and Fine, 2008; Loxley and Hajer, 2019). Another important reference is the theory of public choice, which suggests that public provision would be inherently prone to inefficiency and corruption (Fine, 1999; Starr, 1988).

12 When the concept of privatisation was first adopted in health systems research, it was not clear the importance of distinguishing the type of private actors most directly involved in these changes. However, the present moment gives us the privilege of hindsight. It is implicit that the agents more directly involved in fostering and benefiting from earlier rounds of privatisation were *non-financial companies*. This means companies whose main activity is the production and commercialisation of goods and services – in our case, health companies, specialized in health goods and services. They include hospitals, clinics, care facilities, and providers of medical goods, to name a few. The primary sources of income for these companies were business profits earned from such activities. In this earlier period of reforms, a significant share of private health companies operated under traditional ownership structures, belonging to families or individuals with a professional record in the sector. They presented relatively low levels of leveraging and had no or weaker ties with financial institutions and investors. Their expansion depended on the incremental demand for drugs, equipment, and services. In this work, we will refer to these companies as the *private health sector*.[4]

13 Private insurance companies also played a crucial role in PHS reforms. Although these are technically classified as financial companies, their profile was considerably different when neoliberal reforms came about. In comparison to today, insurance companies were larger in number, smaller in size, and a higher share of them specialized in health insurance services. Non-profit institutions had a higher market share, notably insurance funds with a long history in the sector. A substantial proportion of these companies presented autonomous ownership structures, independent from larger financial companies. Their expansion depended on increasing the number of beneficiaries and the value of premiums.

14 The impacts of privatisation measures are highly debated. The critical literature on privatisation observes that policies were implemented despite systematic evaluation demonstrating superior outcomes for the population or public finances (Bayliss and Fine, 2008). Empirical evidence shows that such measures often contributed to a deterioration in the quantity and quality of public provision and coverage, as well as a worsening of working conditions for healthcare workers. Another frequent observation was the increase in the costs borne directly by individuals, intensifying inequalities in access to health care and increasing total health spending (André et al., 2015; Böhm, 2017; Hassenteufel and Palier, 2007; Laurell, 2016; Ortiz et al., 2015).

II. Financialisation as a distinctive form of PHS change

15 Although the health sector continues to change through mutations in public systems and the growth of private actors, recent events show quantitative and qualitative differences from those described in seminal policy studies (Bayliss et al., 2016; Sestelo, 2017). Studies on the process of *financialisation* seem particularly useful to understand present-day developments, along with others such as *datafication*, *digitisation*, and the inroads of Big Tech firms into health care (Sharon, 2018; Prainsack, 2020).

16 This work focuses on the idea of financialisation, arguing that this concept can be used to identify particular forms of PHS change. To better understand how we could apply the concept of financialisation to examine recent reforms in these systems, it is

necessary to distinguish the agents that participate in what has been broadly called the "private" sector. Along with non-financial companies, *financial companies* are the other main type of entities performing economic activities in this sector (UN, 2010). The main activity of these companies is providing financial services – activities related to supplying, intermediating, and managing funds and investments for other entities. Financial companies receive income from performing these activities in the form of interest payments, dividends, capital gains, and fees. Private financial actors include commercial banks, investment banks, investment funds, insurance companies, pension funds, and asset managers.

17 Current developments in the health sector can hardly be explained without mentioning financial actors. There is an unprecedented expansion of financial actors, instruments, and motives in activities related to the financing, provision, and management of health activities.

18 In the private sector, financial companies and investors are replacing corporate and individual entrepreneurs as the leading agents of change in the industry. Traditional business models coexist with new structures where health goods and service providers are owned, controlled, or highly leveraged by finance (Angeli and Maarse, 2012; Bayliss, 2016; Cordilha and Lavinas, 2018; Vural, 2017; Hunter and Murray, 2019). There are also fewer and larger insurance companies, with a greater share occupied by the for-profit segment. They often belong to larger financial institutions, not specialized in health. As private health companies and financial companies are increasingly interdependent, a distinctive structure appears that would be better characterized as a *private-cum-financialized* health sector.

19 The expansion of health companies and insurers seems ever more dependent on the returns on financial investments and processes of concentration and internationalisation via mergers and acquisitions (M&As). Although the intensity of such trends varies greatly depending on the country and segment, several players are opening capital in the financial markets, acquiring ownership stakes in other companies via open market operations, and taking over smaller companies in closed transactions intermediated by financial corporations (Abecassis et al., 2018; Sestelo, 2017; Cordilha and Lavinas, 2018). Besides providers and insurers, financial actors also seem to have an increasing influence on the design and implementation of global health policies (Stein and Sridhar, 2018; Tchiombiano, 2019). Although financial investments are not necessarily new in the sector, such changes intensified from the 2000s onwards.

The concept of financialisation

20 We can contextualize the advance of the financial sector in health activities as part of a process that has been known in Economic Theory as *financialisation*. Although the origins of the term are obscure, it started being used with increasing frequency to describe processes associated with the growth of the financial sector in size, reach, and power, movements (Gabor, 2018). These movements began in the 1970s and accelerated since the 1990s (Chiapello, 2017). While the relative growth of the financial sector has been a recurrent trend in capitalism (Arrighi, 1994), this expansion now determines patterns of economic growth, income distribution, capital investment, consumption, international trade, capital flows, State action, and even personal beliefs and lifestyles.

The process of financialisation becomes thus the underpinning of the present stage of neoliberal capitalism (Fine et al., 2017). Financialisation studies constitute today a solid body of multidisciplinary research that seeks to investigate the impacts of such a process on different aspects of social, economic, and political life (Mader et al., 2020).

21 The most acknowledged definition of financialisation comes from Epstein (2005, p. 3): "*the increasing role of financial motives, markets, actors, and institutions in the operation of the domestic and international economies*". As the research on the theme evolved, it became evident that this influence extended beyond the economic realm. In this paper, we adopt Aalbers' (2019, p. 4) revised version of this definition, which seems to capture better the current reach of this process: "*the increasing dominance of financial actors, markets, practices, measurements, and narratives, resulting in a structural transformation of economies, firms, States, and households*".[5] Following Bayliss (2016), we consider broad definitions to be the most adequate when investigating how financialisation unfolds upon and within PHS. This is because of the weight of national specificities, making financialisation manifest in different ways that cannot be fully known in advance.

22 The expansion of finance into other sectors constitutes one of the cornerstones of the financialisation process (Epstein, 2005; Chiapello, 2017). As finding new frontiers for extracting financial profits becomes necessary for the continuous accumulation of financial capital, financial actors are on a quest for entering areas from which they were previously insulated (Leyshon and Thrift, 2007). The developments discussed in the previous section provide concrete evidence of how health has been transformed into a place for financial extraction. While financial actors have long been acting in health (insurance funds being a prominent example), the current phase is distinguished by their central role today, driving and benefitting the most from structural changes in public and private health.

23 Research on the "financialisation of health" describes this process as transforming health financing and provision into financial investments and the correlated participation of financial actors in the sector. Another trait often mentioned is the incorporation, by health actors themselves, of features typical of financial corporations (Vural, 2017; Hunter and Murray, 2019; Cordilha, 2020). Although the concept of financialisation is increasingly used to assess these changes, this research focuses almost exclusively on private health actors. It remains unclear how the expansion of financial actors and instruments is reshaping PHS. What does it mean to say that a public health system is undergoing a process of financialisation? To answer this question, we can turn to the literature on the financialisation of the public sector.

Financialisation and public health systems

24 The literature on PHS change has not been oblivious to the growth of financial investments and actors in health care. In the early 2000s, authors were calling attention to the approximation of multinational financial corporations with state institutions and social security funds and the role of private investors in financing public health infrastructure (Iriart et al., 2001; Maarse, 2006; Whitfield, 2006). However, as previously shown, the ways in which the financial sector engages with health activities have increased in scale and scope. This gives reason to suggest that current reforms will open greater possibilities for financial actors and instruments to participate in PHS. One important reason is that the financial sector creates and

manages large volumes of funds that can be *lent to* or *invested in* other entities (always expecting a monetary reward). Against this background, financial deficits in PHS legitimize the welcoming of financial capital through different instruments to address their funding gaps.

25 The usual perspective on the role of the public sector for financialisation in health care emphasizes how governments implement policy shifts that benefit financial actors and activities. Emphasis is placed on regulatory moves in favour of private capital, guarantees of minimum investment returns, and other forms of withdrawing risks for investors. Constraints to public health spending would also indirectly contribute to financialisation by encouraging the demand for private health services and insurance, now a highly financialized sector.

26 However valid, the image of the public sector as a *supporting apparatus* for the financialisation of private health tells half of the story. Several characteristics of PHS make us think that these will be particularly attractive to financial players. Global health spending is around eight trillion dollars, or 10% of the world's GDP. About 60% of global health spending comes from the public sector (WHO, 2019), most of this from countries with institutionalized, comprehensive PHS. These systems require a significant, often the largest part of the country's demand for health goods, services, and workforce. These financial and material bases offer low-risk investment opportunities whose returns can be guaranteed by public revenues and the State's regulatory power.

27 Therefore, to understand how financialisation affects public health care, it is also necessary to examine how this process reshapes internal circuits of financing and provision in PHS. The "internalist" approach to financialisation in the public sector can illuminate this quest. As Chiapello (2017) describes, this approach is concerned not with the financialisation of the economy *through* the State and public policies but with the financialisation *of* the State and public policies themselves. It considers "*the penetration of financialized logics and forms of evaluation in the formulation and implementation of [public] policies, even when these do not involve the financial sector*" (p. 27). Karwowski (2019) adopts a similar approach to investigate the financialisation of the State, defined as "*the increasing influence of financial logics, instruments, markets and accumulation strategies in State activities*" (p. 1002).[6]

28 These studies allow us to identify some particularities in the process of financialisation in the public sphere. First, issues related to financing appear as the main gateway through which private capital can engage and profit from public activities. The search for funds by the public sector to carry out public policies leads to changes in financing circuits – i.e., in the forms of financing public services, policies, and bodies. The introduction of new instruments and strategies creates opportunities for the financial sector to lend to public entities in ever higher and diversified ways. Second, changes in financing circuits seem to depend on a more structural transformation of the public administration in line with financialisation. This includes changes in language, techniques, instruments, organisation, and decision-making criteria of public bodies, mimicking those typical of financial institutions.

Signs of financialisation in different countries

29 Following this framework, we can give examples of how public health activities in different countries are undergoing processes of financialisation – that is, changes in financing circuits to incorporate financial capital, as well as organisational transformations to enable and legitimize them.

30 Bayliss' (2016) seminal study for the National Health Service (NHS) allows us to identify two main ways in which financialisation has unfolded in the case of England. The first was through changes in service provision via outsourcing measures that fostered the participation of private actors in the system. As part of private health companies providing services for the NHS are now owned or backed up by banks and financial corporations, payments from the NHS now end up in the hands of global finance. The second main channel was infrastructure financing. Private Finance Initiatives, the national equivalent for Public-Private Partnerships (PPPs), have been the main source of financing for the construction of NHS hospitals over the last decades. In PPPs, the private sector assumes the funding, management, and (or) operation of a public project, receiving regular future payments from the public sector in return. These projects are highly leveraged by commercial banks and institutional investors, and their asset streams serve to create assets traded in financial markets.

31 In France, we have examined elsewhere (Cordilha, 2020) how recent reforms in the French system, Assurance Maladie (Ameli), were similarly related to financialisation. In this case, the first gateway for financialisation was through financing strategies for Ameli and other social security branches to finance current expenditures and refinance debts. Social Security agencies started issuing financial securities in the markets, raising funds directly from investors, while using the system's revenues to reimburse them in the future. Another gateway was, again, infrastructure financing. A crucial policy in this direction was the provision of government incentives for public hospitals to borrow from commercial banks in order to expand and renew their infrastructure. As Amelie's transfers to hospitals are partially used to repay the debts, financial actors can claim part of the system's funds. Juven et al. (2019) add to this analysis by discussing the spread of PPPs in the French public hospital sector, less intense than in the English case but equally contestable.

32 In Italy, Cusseddu (2011) applies the concept of *securitisation*, a core aspect of financialisation, to explain policy shifts in the Servizio Sanitario Nationale (SSN). Securitisation consists of taking an illiquid asset, such as a long-term debt, and using financial engineering to transform it into a security that can be readily traded in financial markets. Local health authorities started promoting securitisation as a way to pay SSN suppliers. In practice, they sell the suppliers' "receivables" – rights to future payments from the public system – to financial investors, sometimes intermediated by financial agencies specially created for converting one form of debt into another. Securitisation provides local agencies with immediate cash to pay the providers; in the future, instead of paying the latter, the public sector pays investors with added interests.

33 Finally, Loxley and Hajer (2019) describe the financialisation of health and other essential services in Canada, a country with a publicly funded health care system (Medicare). The main channel for financialisation found by the authors was the financing of public hospital construction via PPPs, now the predominant mode of

infrastructure financing for public hospitals. Another channel of financialisation is through Social Impacts Bonds (SIBs). SIBs are financial innovations offered by public entities in which financial investors provide the upfront financing for carrying on specific policy interventions in exchange for future repayment and compensations based on results. Although still in an experimental phase, one of the government's first bonds aimed at financing a health-related policy (the "Community Hypertension Prevention Initiative"). The authors highlight that both forms of private financing for the public sector provide significant profits to investors.

34 The studies above give clear examples of how financialisation can manifest within PHS. They reveal the incorporation of financial instruments and strategies to complement or replace traditional forms of public financing, along with a more direct influence of financial actors in decision-making processes related to public health care. They also express the spread of goals and practices typical of financial institutions throughout public entities. In most cases, these changes started in the second half of the 1990s and gained momentum from the 2000s onwards. These are findings for countries with institutionalized, public, universal health care systems, demystifying the belief that the public health sector is relatively shielded from financialisation.

35 The second question that arises is why these changes associated could be considered a particular kind of PHS reforms.

III. Bridging concepts together: privatisation and financialisation

36 We argue that financialisation represents a distinctive type of PHS reform that is related but not equal to reforms usually associated with privatisation. Today, part of policy shifts creating space for finance to participate in public health financing and provision aims at reaching not private providers of health services and insurance, but of money. This requires specific measures, integrates other types of actors and interests, and poses particular challenges to public systems.

37 Such an argument finds support in the literature. According to Hunter and Murray (2019), "*health care financialisation represents a new phase of capital formation that builds on, but is distinct from, previous rounds of privatisation*" (p. 8). It represents "*the latest emerging phase of health system change — that of the transformation of healthcare into saleable and tradeable assets for global investors*" (p. 2). Similarly, Lavinas and Gentil (2018) state that "*the topic of privatisation alone is no longer sufficient to explain this process of transferring responsibilities, previously in the hands of the State, to profit-oriented companies*" (p. 12). This is because "*the provision of services has as a primary goal shareholder profit, who are, by and large, major international financial groups, distant and oblivious to the content of the services provided*" (*ibid.*). Other authors do not consider financialisation as a different process but rather as a modern form of privatisation (Angeli and Maarse, 2012; Whitfield, 2006). Yet, they also acknowledge that the present phase presents singular features that should be examined in detail.

38 Surprisingly, there have been hardly any attempts to clarify the boundaries between financialisation and other concepts used in PHS research. This gap is noted by Karwowski 2019 (p. 1007), who claims that "*researchers (...) draw only vague distinctions between financialisation and the implementation of neoliberal policies, especially privatisation.*

This is misleading". The next sections contribute to filling this gap by identifying similarities, differences, and connections between the concepts of privatisation and financialisation in PHS.

Financialisation as a distinctive type of PHS change

39 Starting from the similarities, the common element tying together earlier rounds of reforms associated with privatisation and reforms associated with financialisation seems to be the issue of austerity.[7] Financialized strategies appear as a novel way to deal with the old problems of financing public provision in a context of increasing constraints on public revenues and expenditures. PHS face strong incentives for turning toward the financial sector as they need to accommodate growing financing needs within ever more limited budgets, leading them to search for alternative sources of funding.

40 At the same time, alternative financing arrangements are politically appealing for neoliberal governments. They offer opportunities to bypass limits for government debt once, for example, restructured debts can be offset to other entities (Fastenrath et al., 2017; Karwowski, 2019). There is also the opportunity of concealing increases in public spending to the extent that financial expenditures such as interest payments and guarantees can be accounted for separately from direct costs with public provision. This is why Whitfield (2015) refers to financialized practices as "*off-balance sheet schemes*" to increase private finance of public services (p. 1).

41 Due to their hidden costs, financialized strategies may seem less expensive than traditional forms of public financing. Precise comparisons are difficult to make once such moves hinder the assessment of their actual costs. Studies suggest that they are not necessarily superior to models of conventional public financing neither in terms of reducing government spending nor increasing investments (e.g., Bayliss, 2016; Cordilha, 2020; Whitfield, 2006; Loxley and Hajer, 2019). For Whitfield (2015), "*the increase in investments is a myth: the public sector has to pay for the investment plus the profits to investors and is therefore not additional investment. It replaces public investment at a much higher cost*" (p. 9).

42 While austerity is the common thread between privatisation and financialisation, these processes differ in many ways. As already noted, the private actors involved in recent shifts are, to a great extent, financial rather than non-financial actors. Even when there is the incorporation of non-financial actors, such as service providers acting for the public system, many of these are now investment vehicles of financial actors.

43 But the differences go beyond. For example, the rhetoric pushing for the reforms seems to have changed. While PHS were portrayed as inefficient and overspending in the past, criticism today focuses on presenting these systems as financially strapped, which justifies the absorption of private capital. The implicit idea is that traditional sources of public revenues alone cannot provide the necessary funds to maintain and expand access to health care, and private funding would allow closing the gap. Besides a greater availability of funds, other arguments in favour of private capital praise the potential for reducing the costs of public financing and forging a virtuous relationship between different sectors of society (Bayliss 2016; Andreu, 2018; Dentico, 2019; Hunter and Murray, 2019; Tchiombiano, 2019).

44 Another particularity is that the theoretical basis for advancing financialisation in PHS seems weaker than in the case of privatisation. Advocating in favour of private capital for public financing implies that financial markets and institutions are neutral and efficient mechanisms for resource allocation. The assumptions of neutrality and efficiency draw from the foundations of mainstream finance theories (Chambost et al., 2019). However, while past forms of privatisation were grounded on explicit economic theories, one can hardly find mentions to finance theories in proposals for recent reforms. Incorporating private finance appears much more as a pragmatic solution to solve problems in public financing than as a theoretically-informed policy option.

45 The process of financialisation within PHS has the potential not only to intensify adverse impacts associated with privatisation but also to bring in additional ones. First, the transformation of health financing and provision into a financial investment steers decisions concerning what kind of services will be provided, where, to whom, and at what costs and conditions, favouring choices that minimize investment risks and maximize returns (Bayliss, 2016; Lavinas and Gentil, 2018; Hunter and Murray, 2019; Vural, 2017). For public systems, this means that the need to repay debts, guarantee financial returns, and withdraw risks for investors is likely to push for cuts in quality, quantity, and employment conditions, as well as to shifting costs and responsibilities onto individuals. This means intensifying effects observed by critical privatisation studies.

46 The turn to the financial sector can also bring in other challenges due to characteristics inherent to financial markets. These have long been criticized for being opaque, volatile, and forging mechanisms for income concentration (Lemoine, 2018; Fine et al., 2017). For PHS (and public provision at large), introducing financial intermediaries and investors brings less transparency to the use of public money, as it is virtually impossible to know in detail the origins and destination of funds. There is a higher exposition to sudden changes in the costs and availability of funds. Financialisation also poses challenges to democratic participation and income distribution. There is evidence that financial actors seek to influence public decision-making processes by pushing for regulatory shifts allowing them to reap financial returns based on taxpayer money (Dentico, 2019; Karwowski, 2019; Stein and Sridhar, 2018; Whitfield, 2015; Cordilha, 2020).

Bridging concepts: privatisation and financialisation

47 Far from claiming that privatisation was replaced by financialisation, we contend that these are interconnected and mutually reinforcing processes that together are reshaping the landscape of PHS. On the one hand, privatisation can facilitate financialisation as it requires regulatory shifts that enable and expand the possibilities of profit-making in activities related to health financing and provision, facilitating the creation of financial undertakings (Vural 2017; Hunter e Murray 2019). Also, privatisation introduces financial payments for goods and services that are not produced for profit, creating monetary flows within the structures of public financing and provision. This facilitates financialisation once the economic flows of public services can be disaggregated, securitized, and generate assets traded in financial markets (Bayliss, 2016; Hall and Fine, 2012; Fine and Bayliss, 2016).

48 On the other hand, financialisation contributes to fostering privatisation as the expansion of the financial sector generates a vast amount of idle capital for which profitable investment opportunities become increasingly scarce.[8] In this way, the privatisation of public services appears as a prominent outlet for excessive capital looking for profitable investment opportunities. Considering the pressures to cutting expenditure on public services, privatisation can flourish as it meets the interests of both private asset owners and governments (Fine, 2008; Huffschmid, 2009). Public undertakings financed by private capital also present an ideological bias claiming that the building, maintenance, and operation of services should be carried out by private actors, which provides a stimulus for privatisation. This has been concretely evidenced where public services were financed via SIBs and PPPs (e.g., Andreu, 2018; Bayliss, 2016; Loxley and Hajer, 2019). Finally, the injection of financial capital boosts private health companies' expansion and reinforces existing trends for concentration, creating major players with political and economic power to pressure in favour of privatisation (Vural, 2017; Bahia et al., 2016; Sestelo, 2017).

Taking stock

49 PHS are in permanent evolution, and research in the field must be continually updated in light of new theoretical debates and empirical evidence on the direction of these changes. In this paper, we argued that the concept of financialisation could help to better understand recent reforms in these systems. Without intending to exhaust the subject, we sought to give preliminary remarks to stimulate further discussion. We provided evidence that PHS of different countries are undergoing processes of financialisation as they are adopting instruments and strategies underpinned by banks and financial investors. These shifts require changes within the organisation of public entities to open space for financial actors.

50 We also discussed why financialisation and privatisation are interconnected but not identical processes and how the former can intensify and multiply challenges brought by the latter. Further investigation is necessary to unveil the mechanisms through which the process of financialisation reshapes systems in different countries, which are likely to vary in light of national specificities. Another valuable research topic would be to assess the costs of these strategies, especially when considering social, political, and economic impacts that are often excluded from standard calculations.

51 The debates sparked by the COVID pandemic gave a new breath to the discussion on the neoliberal reforms of PHS. They opened space to question the impacts of decades of progressive cuts and constraints in undermining these systems' capacity to fulfil the roles for which they were created. Considering the potential for financialized strategies to expand as a new policy solution for governments facing austerity while also needing to provide public services, the financialisation of PHS represents an important avenue for future investigation.

BIBLIOGRAPHY

Aalbers, M., 2019. Financialization, in Richardson, D. (Ed.): The International Encyclopedia of Geography. Oxford, Wiley.

Abecassis, P., Coutinet, N., Domin, J.-P., 2018. Les Transformations de l'Assurance Maladie Complémentaire à la Lumière de la Démutualisation/Hybridation des Banques Coopératives. *REI* 161.

Alles, L. 2018. *Composition et Dynamiques du Paysage Hospitalier Français*. Master Dissertation. Université Paris Nanterre, EHESS.

André, C., Batifoulier, P., Jansen-Ferreira, M., 2015. Privatisation de la Santé en Europe. CEPN Working Papers 2015–02.

André, C., Hermann, C., 2009. Privatisation and Marketisation of Health Care Systems in Europe, in Frangakis, M. et al. (Eds.), *Privatisation Against the European Social Model*. London, Palgrave Macmillan.

Andreu, M., 2018. A Responsibility to Profit? Social Impact Bonds as a Form of Humanitarian Finance. *New Political Sci.* 40.

Angeli, F., Maarse, H., 2012. Mergers and Acquisitions in Western European Health Care. *Health Policy 105.*

Bahia, L., Scheffer, M., Tavares, L.R., Braga, I.F., 2016. From Health Plan Companies to International Insurance Companies. *Cad Saúde Pública* 32.

Batifoulier, P., 2015. Aux Origines de la Privatisation du Financement du Soin. *R Régulation [En ligne] 17.*

Batifoulier, P., Touzé, V., 2000. *La Protection Sociale*. Paris, Dunod.

Bayliss, K., 2016. The Financialisation of Health in England. FESSUD Working Papers 131.

Bayliss, K.; Fine, B. (2008), *Privatization and Alternative Public Sector Reform in Sub-Saharan Africa*. London, Palgrave Macmillan.

Böhm, K., 2017. *The Transformation of the Social Right to Healthcare*. London, Routledge.

Chiapello, È., 2017. La Financiarisation des Politiques Publiques. *Mondes Dev* 178.

Chambost, I., Lenglet, M., Tadjeddine, Y. (2019) Introduction, in Chambost, I., Lenglet, M., Tadjeddine, Y. (Eds.), *The Making of Finance*. New York, Routledge.

Cordilha, A.C., 2020. How Financialization Reshapes Public Health Care Systems: The Case of Assurance Maladie. CEPN Working Papers 2020–03.

Cordilha, A.C., Lavinas, L., 2018. Transformações dos Sistemas de Saúde na Era da Financeirização. *Cien Saude Colet* 23.

Cusseddu, V., 2011. Capire la Finanza: La Cartolarizzazione e l'Esplosione Della Crisi Finanziaria. Florence, Fondazione Culturale Responsabilità Etica Onlus.

Dentico, N., 2019. Making Health a Global Bankable Project, in Citizens for Financial Justice, Spotlight on Financial Justice.

Fastenrath, F., Schwan, M., Trampusch, C. 2017. Where States and Markets Meet. *New Pol Econ* 22.

Fine, B., 1999. Privatization, in Vlachou, A. (Ed.), *Contemporary Economic Theory*. London, Palgrave Macmillan.

Fine, B., Bayliss, K., 2016. Paper on Theoretical Framework for Assessing the Impact of Finance on Public Provision. FESSUD Working Paper Series 192.

Fine, B., Hall, D., 2012. Terrains of Neoliberalism, in *Alternatives to Privatization*. London: Routledge, Pretoria: HSRC.

Fine, B., Saad-Filho, A., Bayliss, K., Robertson, M., 2017. Thirteen Things You Need to Know About Neoliberalism. *Crit. Sociol.* 43.

Frangakis, M., Huffschmid, J., 2009. Privatisation in Western Europe, in Frangakis, M., Hermann, C., Huffschmid, Jorg, Lorant, K. (Eds.), *Privatisation against the European Social Model*. London, Palgrave Macmillan.

Gabor, D., 2018. Understanding the Financialisation of International Development Through 11 FAQs. Washington D.C, Heinrich Böll Stiftung.

Giovanella, L., Escorel, S., Lobato, L. de V.C., Noronha, J. de C., Carvalho, A.I. de, 2012. *Políticas e Sistema de Saúde no Brasil*. Rio de Janeiro, Fiocruz.

Guttmann, R., 2016. *Finance-led capitalism*. New York, Palgrave Macmillan.

Hassenteufel, P., Palier, B., 2007. Towards Neo-Bismarckian Health Care States? *Soc Policy Adm* 41.

Hooda, S.K., 2016. *Health in The Era of Neoliberalism*. ISID Working Paper 196.

Huffschmid, J., 2009. Finance as a Driver of Privatisation, in Hermann, C., Lóránt, K. (Eds.), *Privatisation Against the European Social Model*. London, Palgrave Macmillan.

Hunter, B.M., Murray, S.F., 2019. Deconstructing the Financialization of Healthcare. *Dev Change* 50.

International Monetary Fund (IMF), 2017. Monetary and Financial Statistics Manual and Compilation Guide. Washington D.C.

Iriart, C., Merhy, E.E., Waitzkin, H., 2001. Managed care in Latin America. *Soc Sci Med* 52.

Karwowski, E., 2019. Towards (De-)Financialisation: The Role of the State. *Camb J Econ* 43.

Laurell, A. C. 2016. Las Reformas de Salud En América Latina. *Cuad de Relac Laborales* 34.

Lavinas, L., Gentil, D., 2018. Brasil Anos 2000: A Política Social Sob Regência da Financeirização. *Novos Est CEBRAP* 37.

Lemoine, B. (2018). Dettes et Devoirs d'État, in Karsenti, B., Linhardt, D. (eds): *État et Société Politique*. Paris: Editions de l'EHESS.

Lewalle, H. 2006. A Look at Private Health Care Insurance in the European Union. *Rev Fr Aff Soc* 6.

Loxley, J., Hajer, J., 2019. Public-Private Partnerships, Social Impact Bonds, and the Erosion of the State in Canada. *Stud Political Econ* 100.

Maarse, H., 2006. The Privatization of Health Care in Europe. *Journal Health Polit Policy Law* 31.

Mackintosh, M., Koivusalo, M. (Eds.), 2005. Commercialization of Health Care. New York, Palgrave Macmillan.

Mader, P., Mertens, D., Zwan, N. van der, Mertens, D., Zwan, N. van der, 2020. Financialization: An Introduction, in *The Routledge International Handbook of Financialization*. New York, Routledge.

MacMillan Dictionary, 2021. Dictionary entry for 'Company'. Available at: https://www.macmillandictionary.com/dictionary/british/company?q=companies (Accessed: 8 January 2021).

Mercille, J., Murphy, E., 2017. What is Privatization? *Environ Plan* 49.

Mulligan, J., 2016. Insurance Accounts. *Med Anthropol Q* 30.

Ortiz, I., Cummins, M., Capaldo, J., Karunanethy, K., 2015. *The Decade of Adjustment*. International Labour Office, Extension of Social Security Series 53.

Prainsack, B., 2020. The Value of Healthcare Data: To Nudge, or not? *Policy Stud* 41.

Preker, A., Harding, A., 2003. The economics of hospital reform, *World Hosp Health Serv* 39(3).

Roemer, M.I., 1993. National Health Systems Throughout the World. *Annu Rev Public Health* 14.

Rothgang, H., Cacace, M., Frisina, L., Grimmeisen, S., Schmid, A., Wendt, C., 2010. *The State and Healthcare*. London, Palgrave Macmillan.

Sagan, A., Thomson, S. (Eds.), 2016. Voluntary Health Insurance in Europe. World Health Organization, Observatory Studies Series 42.

Sestelo, J.A., 2017. *Planos e Seguros de Saúde do Brasil de 2000 a 2015 e a Dominância Financeira.* Doctoral Thesis. Universidade Federal do Rio de Janeiro, IESC.

Sharon, T., 2018. When Digital Health Meets Digital Capitalism, How Many Common Goods Are at Stake? *Big Data & Society* 5.

Starr, P.E., 1988. The Meaning of Privatization. *Yale Law Policy Rev* 6.

Stein, F., Sridhar, D., 2018. The Financialisation of Global Health. Wellcome Open Research 3.

Tchiombiano, S., 2019. Public Health, Private Approach. *Face à Face* [online].

United Nations, 2010. System of National Accounts 2008.

Vallin, J., Meslé, F., 2006. Origines des Politiques de Santé, in: Caselli, G., Wunsch, G., Vallin, J. (Eds.), *Démographie: Analyse et Synthèse VII*. Paris, INED.

Vural, I.E., 2017. Financialisation in Health Care. *Soc Sci Med* 187.

Whitfield, D., 2006. A Typology of Privatisation and Marketisation. European Services Strategy Unit, Research Report 1.

Whitfield, D., 2015. Alternative to Private Finance of the Welfare State. Australian Workplace Innovation and Social Research Centre.

World Health Organization (WHO), 2010. Monitoring the Building Blocks of Health Systems. Geneva.

World Health Organization (WHO), 2019. Global Spending on Health Report. Geneva.

NOTES

1. For a discussion on definitions of the term "neoliberalism" and the features of this period, see Fine et al. (2017).

2. This should not be seen as an exhaustive list; other terms have also been used to assess reforms, although their use appears to be less common or circumscribed to specific countries. A relevant mention is the notion of *corporatisation* (Preker and Harding, 2003).

3. The stylized facts of privatisation and financialisation presented in the following sections were drawn from a non-exhaustive review of theoretical and empirical studies for central and peripheral economies. The complete list of references can be found in Cordilha (2020) and the respective sections of this work. The empirical evidence to support this claim was based on studies such as Abecassis et al. (2018), Alles (2016), André and Hermann (2009), Bahia et al. (2016), Batifoulier (2015), Laurell (2016), Lewalle (2006), Sagan and Thomson (2016), and Sestelo (2017).

4. This term will be used in contrast to financial companies, the object of the following section. The definitions of financial and non-financial companies presented in this work are based on those used in national accounting systems (IMF, 2017; UN, 2010). The original terminology used in national accounts employs the term "corporation" instead of "companies", but we replaced it to avoid confusion with the typical usage of the term in the US associated with large-scale businesses owned by different shareholders. We use the term "companies" in a broad sense that includes several types of business (MacMillan Dictionary, 2021). We should also mention non-profit institutions, which produce and distribute goods and non-financial services outside of the market logic and cannot provide profits or financial gains to those that manage them.When discussing private health companies in this work, we are referring mainly to for-profit companies (while recognizing that non-profit institutions are also undergoing specific transformations in this phase of capitalism).

5. These definitions converge with narrower conceptions of financialisation used in the literature. For a systematisation of different definitions, see Mader et al. (2020).

6. The idea of "State" is applied with a broad meaning, encompassing public entities at large (including central governments, local government, and social security institutions, among others). This is important because the term is sometimes used in a narrow sense as a synonym for the central government, excluding other areas of the public administration such as PHS latter.

7. Fiscal austerity can be understood as a set of government policies to reduce public expenditures in terms of the GDP (Ortiz et al., 2015).

8. The dismantling of the "Bretton Woods" system and the following liberalisation of global capital markets , the internationalisation of production, technological advances in communication and computer sciences, the deployment of financial innovations, and the rise of the neoliberal paradigm are among some of the events of the 20th century that contributed to expanding the size of the financial sector and the volume of financial capital in circulation (see, e.g., Guttmann, 2016; Huffschmid, 2009; Fine, 2008).

ABSTRACTS

Public Health Systems (PHS) are in constant evolution. Research in the field must be continuously updated considering the direction of these changes. The present stage of capitalism is underpinned by the process of financialisation – the expansion of the financial sector in size, scale, and power. Although the process of financialisation is reshaping PHS, the mechanisms through which this occurs remain poorly investigated. This article aims to discuss how the concept of financialisation can be incorporated into the conceptual framework currently used to examine PHS reforms. This allows us to understand better the drivers, features, and impacts of recent policy shifts. In light of the potential of financialized strategies to grow as a new solution for financially strained systems, refining the concepts used in PHS research represents a crucial avenue of investigation.

Les systèmes de santé publique (SSP) sont en constante évolution. La recherche dans ce domaine doit être continuellement mise à jour en tenant compte de l'orientation de ces changements. Le capitalisme contemporain est sous-tendu par le processus de financiarisation - l'expansion du secteur financier en taille, échelle et pouvoir. Bien que le processus de financiarisation remodèle les SSP, les mécanismes par lesquels cela se produit restent peu étudiés. L'objectif de cet article est d'examiner comment le concept de financiarisation peut être intégré dans le cadre conceptuel actuellement utilisé pour examiner les réformes des SSP. Cela nous permet de mieux comprendre les moteurs, les caractéristiques et les impacts des changements de politique ciblant ces systèmes. Compte tenu du potentiel de croissance des stratégies financiarisées en tant que nouvelle solution pour des systèmes de santé financièrement fragiles, il est essentiel de bien préciser les concepts utilisés dans la recherche sur ces systèmes.

INDEX

Mots-clés: santé publique, systèmes de sante, sécurité sociale, privatisation, financiarisation
Keywords: public health, health systems, social security, privatisation, financialisation
JEL Code I13 - Health Insurance; Public and Private, I18 - Government Policy • Regulation • Public Health, H55 - Social Security and Public Pensions, E44 - Financial Markets and the Macroeconomy, L33 - Comparison of Public and Private Enterprises and Nonprofit Institutions • Privatization • Contracting Out

AUTHOR

ANA CAROLINA CORDILHA

Université Sorbonne Paris Nord, Centre d'Économie Paris Nord (CEPN)