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When care becomes capital

Without urgent safeguards, financialisation risks locking care systems into a race to the bottom

I have spent years listening to care workers across the world. Home care workers juggling multiple jobs, nurse aids holding together hospital systems on poverty wages, technicians stretched beyond safe limits. Their stories differ by country, but the underlying reality is increasingly the same: the systems they sustain are being reshaped by financial interests that do not see or value their dedication to those they care for.

Today, I am more convinced than ever that we are approaching a breaking point.

Profiteering by design

Our new UNI Global Union report, *The High Cost of Financialised Care*, examines healthcare systems across six countries. What we found is deeply troubling. Financial actors – private equity firms, investor-backed hospital chains and opaque insurance intermediaries – are embedding themselves into care systems in ways that systematically undermine working conditions and patient care.

This is not the urgently needed investment aligned with public needs. It is profiteering by design.

In Colombia, where the state provides over 70 per cent of healthcare funding, most of that money flows to private intermediaries – many foreign-owned – whose primary driver is to deliver profits, not patient care. Over the previous decades, this system has experienced significant instability and criticism of underfinancing. Reform efforts led by the left-wing Gustavo Petro government in 2024 have been blocked by politically entrenched corporate interests, most notably the multinational Keralty Group, who own EPS Sanitas, the second largest insurance intermediary company in Colombia.

In Kenya, public health insurance was reformed in 2024 through the

establishment of the Social Health Authority (SHA), a state corporation of the Government of Kenya. The SHA replaced the previous National Hospital Insurance Fund (NHIF), which had existed since 1966 and had faced sustained criticism for failing to cover more than 20 per cent of the population by requiring payment of premiums, thereby pricing out most Kenyans. But what was presented as a landmark reform was subsequently revealed by the country's Auditor General to be a for-profit contract outsourced to a private consortium, extracting management fees of approximately five per cent per claim on an $800 million programme.

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Finally, in the Dominican Republic, just three insurers dominate the country's health insurance market and post recorded profit margins of up to 33 per cent, raising concerns about competition and access to affordable care.

Financialisation changes how care systems function by introducing incentives that prioritise short-term financial returns over long-term resilience. It sets off a spiral effect that pushes down wages and fragments employment. It reduces transparency through complex ownership structures. And it limits the ability of governments to act in the public interest.

One of the clearest warning signs is rising debt. In Brazil, five conglomerates now dominate the healthcare sector, having expanded through aggressive acquisitions financed by debt, only to pass the pressure onto workers when economic conditions tightened. Real wages fell. Many health workers were forced to work 60 to 80 hours a week just to scrape by with the essentials. And when workers are stretched to that extent, patient care inevitably suffers. Because quality care cannot be delivered on the back of exhaustion and insecurity.

Perhaps the most alarming lesson is that public funding alone no longer guarantees public accountability. While governments are paying for care, they are too often not in control of how it is delivered or who ultimately benefits. At the same time, the scale of financial capital entering healthcare continues to grow rapidly. Without safeguards, that capital will continue to reshape systems in ways that put profit before people.

We do not have to accept this trajectory.

The future of care

Investors can play a more constructive role in shaping standards in the care sector. Through the Investor Initiative for Responsible Care, UNI convened over 160 investors representing more than $4.4 trillion in assets under management to support higher standards across the nursing home sector. By using their collective voice, these investors are calling on policymakers to raise standards on freedom of association, staffing levels and transparency — thereby countering the usual industry lobbying.

Governments can and must act now to define what investment in care looks like. This includes five urgent steps.

First, public care systems must be strengthened. They remain the most effective safeguard against extractive financial practices.

Second, governments must mandate full transparency. If public money is involved, there must be clear visibility into ownership chains, debt levels and financial flows across all care providers and financial actors in care.

The pursuit of profit should not come at the expense of workers' livelihoods or patients' well-being.

Third, strong regulatory guardrails to limit the most harmful financial practices, particularly excessive leverage and profit extraction, must be introduced.

Fourth, governments must involve workers and their unions in policymaking. Care workers know where systems are failing because they live those failures every day.

And lastly, gender analysis needs to be embedded into all care policies and investment decisions. The care workforce is predominantly women, and financialisation risks deepening existing inequalities.

This is not an abstract policy debate. It is about the future of care itself. Healthcare is not just another sector of the economy. It is a cornerstone of our societies, a reflection of our collective commitment to dignity and human life. Treating it as an asset class to be optimised for returns undermines that foundation core principles that we must uphold.

I believe in investment that strengthens care systems. I believe in innovation and efficiency. But I do not believe that the pursuit of profit should come at the expense of workers' livelihoods or patients' well-being. Without guardrails, that is exactly what is happening.

The window for action is still open, but it is narrowing. If governments fail to act now, financialisation will become entrenched and far harder to reverse.

Care should serve people, not profits. That is the principle we must defend.



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