Global public–private partnerships: part I – a new development in health?

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The proliferation of public–private partnerships is rapidly reconfiguring the international health landscape. This article (part I of two on the subject) traces the changing nature of partnership, and discusses the definitional and conceptual ambiguities surrounding the term. After defining global public–private partnerships (GPPPs) for health development, we analyse the factors which have led to the convergence of public and private actors and discuss the consequences of the trend toward partnership between UN agencies (including the World Bank) and commercial entities in the health sector. Generic factors such as globalization and disillusionment with the UN, and factors specific to the health sector, such as market failure in product development for orphan diseases, are examined. Reviewed are the interests, policies, practices and concerns of the UN, the private-for-profit sector, bilateral organizations, and governments of low-income countries with respect to public–private partnership. While GPPPs bring much needed resources to problems of international health, we highlight concerns regarding this new organizational format. Part II, which will be published in the May issue of the *Bulletin*, presents a conceptual framework for analysing health GPPPs and explores the issues raised.

Keywords: world health, trends; intersectoral cooperation, history; public sector; private sector; United Nations; public policy.

Voir page 558 le résumé en français. En la página 559 figura un resumen en español.

Introduction

The latter half of the 1990s witnessed a burgeoning number of initiatives involving collaboration between the corporate and public sectors with the purpose of overcoming market and public "failures" of international public health, using global public–private partnerships for health development. One example of such a partnership is provided by the International AIDS Vaccine Initiative, incorporating a range of public and private interests which have undertaken to share the risks, costs and benefits of research into an effective vaccine against human immunodeficiency virus (HIV). While such partnerships bring major resources into the international public health arena and have the potential to benefit large populations, they also blur the traditional distinctions between the public and private sector's aims and responsibilities.

This is the first of two articles in which we explore global public–private partnerships. In part I we review the concept of partnership and delineate what we mean by global public–private partnerships (GPPPs) for health development. We then turn to the context from which these partnerships are emerging, focusing particularly on changes confronting the United Nations and the corporate community during the 1990s. Part II, which is scheduled to appear in the next issue of the *Bulletin*, discusses a conceptual framework for understanding the different forms of global public–private partnership in the health sector, and explores the implications of GPPPs for the 21st century, looking at issues of governance and equity.

What are GPPPs for health development?

The notion of partnerships for development cooperation is not new. As early as 1969, the Pearson Commission on International Development considered the nature of partnership between donors and recipient countries. The Commission suggested that the formation of a partnership requires the specification of reciprocal rights and obligations, and the establishment of clear objectives that are beneficial to both parties (*1*). Subsequently, numerous definitions have been proposed to characterize what partnership means, focusing on objectives, responsibilities and gains. The essence of partnership is "a relationship

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based upon agreement, reflecting mutual responsibilities in furtherance of shared interests" (*2*). In the health sector, WHO describes partnership as a means to "bring together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles" (*3*). In this definition, agreement on key principles is thought to be crucial, as well as the maintenance of a balance of power between the parties, to enable each to retain its core values and identities. WHO proposes that these core ethical principles should include the following: beneficence (should lead to public health gain); non-maleficence (must not lead to ill-health); autonomy (should not undermine each partner's autonomy); and equity (benefits should be distributed to those most in need) (*4*).

Some definitions add an operational element by envisioning a partnership as "a collaborative relationship between entities to work toward shared objectives through a mutually agreed division of labour" (*5*). This type of partnership may also include "a mechanism to assess success and make adjustments" (*5*); or "an agreement to work together to fulfil an obligation or undertake a specific task by committing resources and sharing the risks as well as the benefits" (*6*).

However, although partnership is often defined as having some or all of the above features, the term suffers from a lack of specificity. Although donor–recipient relations remain the dominant partnership focus, for many aid agencies the basis of these relations has today moved away from geopolitical or historical relations towards more selective recipient–partner commitments, longer time horizons, responsiveness to recipient priorities and equality, as expressed through sector-wide approaches (*5, 7, 8*). Nongovernmental organizations (NGOs) still talk of community groups as their dominant partners, but are increasingly exploring the implications of partnership with the corporate sector (*9*). The secondment of private sector staff to multilateral organizations, such as the secondments from Merck & Co. and the World Self Medication Industry to WHO's Tobacco Free Initiative, has also been described as a partnership (*10*).

If the notion of partnership is non-specific, so is the definition of partner. The Global Forum for Health Research (*11*) defines a partnership as "... a group of allies sharing the goals, efforts and rewards of a joint undertaking". Allies, however, may bring different levels of knowledge, expertise, and finance to partnerships, which could be complementary but might also bestow different levels of influence. Allies may use different terms to describe themselves: as partners in a partnership to one audience and as donors to another. The International AIDS Vaccine Initiative describes itself as having just five partners, but has an additional 17 organizational donors (not including many individuals). The role of any one partner may change over time, from active to passive. Partners may be defined by organization or individual, and might also be involved at different levels within the partnership. For example, although the corporate sector might not be involved in the governing bodies it may act as an integral partner at a task force, expert committee or other level. This was seen in the Children's Vaccine Initiative, where the private sector was involved only at the operational level (*12*).

Although a GPPP might refer to a relationship between just two parties (e.g. a fund-raising venture between UNICEF and TransContinental Hotels), we have focused on partnerships which involve more than two partners because these are more complex forms of new global partnership, and less is known about them. For example, in pursuing partnerships, industry has tended either to establish a foundation, or to work through an existing or new non-profit organization in order to interface with its public sector partners. Thus Merck & Co. involved the Task Force on Child Survival and Development[a] in its Mectizan Donation Program, as did Glaxo Wellcome for their donation of Malarone (atovaquone) (*13, 14*). Many of these partnerships also include bilateral or civil organizations, including academic or other research institutes, ministries of health or indigenous NGOs in developing countries.

This article also focuses mainly on partnerships related to drugs and vaccines developed and applied to infectious diseases, because this is the area where the greatest partnership activity has taken place. However, GPPPs are emerging in a number of additional health-related fields, including tobacco dependence (*15*) and contraceptive technology development (*16*).

It is beyond the scope of this article to characterize partnerships on the basis of the definition of partner or to specify what level of involvement is required to be considered a partner, but this remains an important area for research. Instead, we explore specific forms of partnerships that are global in scope and involve collaboration between public and private-for-profit organizations in the health sector**.** We define a health GPPP as a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour.

Why have partnerships emerged?

Background

Until the late 1970s, there was minimal collaboration between private and public sectors within the UN or international development system, and relationships were often abrasive, with little trust on either side. Partnerships that did exist were largely limited to

[a] Task Force on Child Survival and Development is itself a partnership between WHO, UNICEF, UNDP, the World Bank and the Rockefeller Foundation with the secretariat based at the Carter Center, Atlanta, GA, USA.

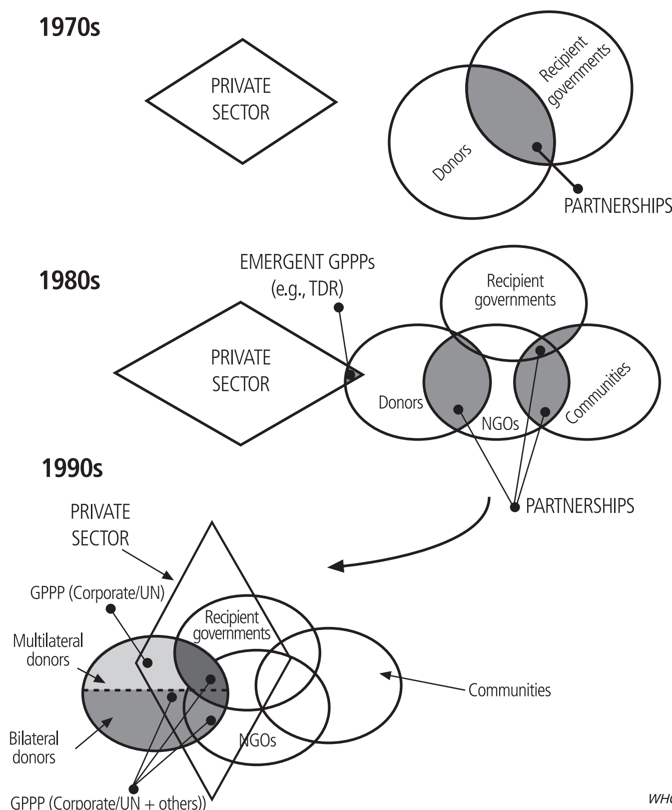
public sector relationships between donor agencies and recipient country governments (*5*). Although the UN Charter allowed for suitable arrangements for consultation with non-governmental, not-for-profit organizations, the relationship between UN agencies and NGOs in the 1960s hardly constituted partnerships. Consultation was formal, sometimes challenging, with NGOs often being described as "pressure groups" (*17*).

By the late 1970s and early 1980s, as neoliberal ideologies influenced public policy and attitudes, relationships began to change (*18*). Influential international organizations acknowledged and championed a greater role for the private sector (*19*). Donors looked beyond the state for collaborators in project work, and began to form broader relationships. For example, the World Bank adopted its first Operational Policy Note on NGOs in 1981, and established an NGO–World Bank committee in 1982 and a central NGO Unit in the mid-1980s. Donor agencies channelled increasing funds through NGOs and by 1998 a total of 15% of total overseas development aid was filtered through NGOs (*20*). Joint action between UN agencies such as UNICEF and WHO, and NGOs such as the Baby Food Action Network, challenged industry over the International Code on Breast-milk Substitutes and essential drugs policies (*21, 22*). While some of these encounters were initially conflict-ridden and characterized by distrust, by the end of the 1980s polemics had given way to tentative explorations of ways to link up NGOs, industry and the public sector. Fig. 1 illustrates the shift in private and public roles.

Entente between private-for-profit (corporate) and public sectors in particular, was the result of a number of changes in the context of international cooperation for health. First, the 1990s were marked by an ideological shift from "freeing" to "modifying" the market. While many claim that the "age of medicine as a pure public service is over" (*23*), most advocates of free markets have moderated their position, seeing a continuing role for the public sector, particularly within the area of health where markets are often inefficient and equity is harder to achieve (*24*). A World Bank official, for example, noted that "where drugs are concerned, a pure market mechanism generally does not work... we are therefore not really speaking of creating a pure market situation, but a modified market mechanism incorporating a whole series of safeguards to protect all the parties concerned" (*25*).

This ideological shift is not based solely on economic philosophy but also on changes to the prevailing sociopolitical orthodoxy. In the United Kingdom, New Labour's "third way" ethos exemplifies a form of neocorporatism[b] in which a variety of stakeholders, including private sector representatives, are believed to have a legitimate say in public policy-making (*27*). In the context of this ideological shift, it has been suggested that the UN may see the benefits of industry partnership as "re-legitimizing" the UN and thereby enabling it to regain a more central position in global policy-making. For example, the Corporate Europe Observatory argues that "... working with the International Chamber of Commerce diversifies the UN's image, which in some countries, including the United States, is not ideal".

Fig. 1. **Shift in private and public relationships.** (Shown is the shift in the relationships between organizations over this time, with the gradual convergence of the public and private-for-profit sectors after an initial period marked by discreet or minimal collaboration, to an era in which linkages were forged more openly, to current full-scale enthusiastic endorsement of partnership).



Influential factors in the emergence of GPPPs

The second contextual shift that has created fertile ground for GPPPs, is the growing disillusionment with the UN and its agencies. Concerns about the effectiveness of the UN, including increasing evidence of overlapping mandates and interagency competition, led directly towards the establishment of partnerships to deal with specific and limited issues. The Task Force on Child Survival and Development, which represents an early partnership established between a number of UN agencies and the Rockefeller Foundation, emerged out of impatience with the rivalry between WHO and UNICEF over primary health care, differences in approaches,

[b] As early as 1987, Peters (*26*) described the corporatist nature of GPPPs (i.e. a form of third party government).

and the perception of WHO's lack of progress on immunization (*28*). Partnerships that are housed outside the UN bureaucracy are viewed as a way of getting things done, and, when industry is involved, getting things done efficiently. Discussions surrounding the establishment of the Medicines for Malaria Venture (a public–private drug research partnership) led to agreement that "the organization should run as a not-for-profit-business and be based on operational paradigms of industry, not the public sector" (*29*).

Negative perceptions of UN effectiveness have provided financial impetus for partnerships in that donors have imposed a policy of zero real growth in UN budgets and shifted toward supplementary (i.e. voluntary and earmarked) funding. These funding trends have made GPPPs attractive to the UN: resources provided by the private sector "are more than welcome; they are necessary" (*30*).

Third, there has also been an increasing recognition that the determinants of good health are very broad and the health agenda is so large that no single sector or organization can tackle it alone. Emerging health problems required a range of responses beyond the capacity of either the public or private sectors working independently, and therefore bridges had to be built between them (*31*). Some specific health threats are so formidable that single sectors are unlikely to have the necessary resources (political, technical and scientific) to address them (e.g. the development of vaccines against malaria or acquired immunodeficiency syndrome (AIDS)).

The previous point relates to a new appreciation and explicit understanding of how the actions of one sector affect the ability of the other to achieve its goals, and how partnership can result in win-win interactions between private and public actors. There was, for example, an "honest recognition by the public sector" of the "unique, unrivalled monopoly" of the pharmaceutical industry in drug and vaccine development: "They own the ball. If you want to play, you must play with them" (*32*). Batson has demonstrated how the public sector's maximization of the role of immunization is "inextricably linked" to the decisions or behaviour of the vaccine-pharmaceutical industry, and conversely how the behaviour of industry is conditioned by the signals sent out by major public sector players (*33*). She has argued that UNICEF's centralized procurement of developing countries' vaccines for the Expanded Programme on Immunization (EPI) ensured low prices, but also signalled that the public sector was not interested in encouraging pharmaceutical companies to invest in research and development for new vaccines that might benefit poor countries.

Changing markets and technology have heightened this appreciation of inter-dependence. In particular, new developments in biotechnology are making drug and vaccine discovery and development increasingly expensive (*34, 35*), as are changes in intellectual property rights (*36*). Concomitantly, extensive consolidation of the pharmaceutical industry has led to greater competition within companies thus increasing the opportunity costs associated with investment in tropical diseases (*37–39*). These changes have encouraged some health advocates to explore ways in which public and private decision-makers could join forces to develop and provide health promoting goods to developing countries at an affordable price, while minimizing risk and guaranteeing a return to the private sector.

Emerging avenues include the concept of tiered pricing for products, e.g. the Children's Vaccine Initiative which championed the idea that EPI vaccines should be available to public sector programmes at prices reflecting the countries' ability to pay (*40, 41*); guaranteeing markets to encourage drug/vaccine discovery and commercialization, e.g. the International AIDS Vaccine Initiative proposed an International HIV/AIDS Purchase Fund that would provide loans to low-income countries for HIV vaccine purchase once one is developed (*42*); and public sector assumption of risks associated with drug/vaccine development in exchange for intellectual property rights – e.g., the Medicines for Malaria Venture, which provides public resources to private drug companies to develop promising drug candidates (*29*).

Economic globalization may also have provided impetus to the private sector to enter into partnerships with the UN. "Business believes that the rules of the game for the market economy, previously laid down almost exclusively by national governments, must be applied globally if they are to be effective. For that global framework of rules, business looks to the United Nations and its agencies" (*43*).

GPPPs and the corporate sector

The trend towards GPPPs may be related to the change in public attitudes and the growing response of the private sector to concerns and vocal demands for corporate responsibility and accountability. Corporations themselves have realized their need to take into account broader responsibilities to society (*44*). This recognition has been stimulated by the strength of consumer, environmentalist, and other civil society group actions in industrialized countries, which have challenged international companies' policies in a number of spheres and won considerable concessions (*45*). For example, the announcement by Monsanto in late 1999 that it would not be pursuing sterile seed technology because of public concern about such developments (*46*).

GPPPs can improve corporate image. One company executive explained that public pressure was of highest consideration in terms of why his company sought partnerships with the public health sector (*47*). The positive experience of Merck's donation of Mectizan (ivermectin) to onchocerciasis control programmes in a number of countries where it is endemic played an extremely important role in stimulating further "pharmaco-philanthropy" (*48*).

The context of global public–private partnerships

This section analyses the perspectives of the United Nations system, industry, bilateral donors and recipient governments with respect to GPPPs. Box 1 summarizes UN perspectives on the benefits of partnership.

Box 1. **United Nations interests in global public-private partnerships**

1. **Harness private sector for human development** — perception that public sector cannot single-handedly bring about successful sustainable development.
2. **Bestow legitimacy on United Nations** — being seen to involve industry in the affairs of the UN may win it support among various constituencies (e.g., American Congress).
3. **Bestow authority on United Nations** — public–private partnerships fit closely with current third-way politics (i.e. corporatist political theory involving industry as a stake-holder in the affairs of the UN may harness industrial support for its work).
4. **Enable the UN to fulfil its functions and mandates** — in light of zero real growth budgets, financial, material, technical and other assistance from the private sector may allow the UN and its agencies to meet its commitments.
5. **Enable the UN agencies to leverage financing and advice from the private sector** — in furtherance of UN mandates.

United Nations

In today's interdependent world, the United Nations and the private sector need each other.

UN Secretary-General Kofi Annan (*49*)

In 1998, Kofi Annan addressed the World Economic Forum on his overhaul of the UN, describing it as a 'quiet revolution' which would enable it "to face the challenges of a new global era" and place it in "a stronger position to work with business and industry" (*50*). He also indicated that a fundamental shift had occurred whereby the United Nations, which once dealt only with governments, recognized "that peace and prosperity cannot be achieved without partnerships involving governments, international organizations, the business community and civil society."

Shortly thereafter, Kofi Annan met with representatives of the International Chamber of Commerce (ICC), which produced a joint statement on common interests, proposing that "broad political and economic changes have opened up new opportunities for dialogue and cooperation between the United Nations and the private sector" (*51*). Two main areas were suggested: establishing an effective regulatory framework for globalisation; and raising the productive potential of poor countries by promoting the private sector. Within this context, there was a call to "intensify the search for partnerships."

A year later, Annan reiterated his case to industry and the UN, proposing that industry and the UN enter into a "global compact of shared values and principles, which will give a human face to the global market" and broadened the sphere of mutual interests to human rights, labour standards and environmental practice (*52*). The ICC responded positively, but not surprisingly, suggesting that the compact address a fourth value: "the economic responsibility incumbent upon any company to its customers, to its employees and to its shareholders" (*53*).

United Nations Conference on Trade and Development (UNCTAD)

UNCTAD is the principle organ of the United Nations in the field of trade and development. Its goals are to maximize the trade, investment, and development opportunities of developing countries and to assist them to face the challenges of globalization. In 1999, UNCTAD launched a partnership initiative with industry through which UNCTAD and ICC would work jointly to produce investment guides for six low income countries with the aim of encouraging greater foreign direct investment. In each country a large transnational corporation will sponsor the effort (*54*). According to Maria Cattaui, the Secretary-General of ICC, "the project gives practical expression to the closer working relationship between ICC and the UN system" (*55*). As a result of UNCTAD involvement with the ICC, however, concern has been voiced that UNCTAD is "losing its direction and spirit" (*54*).

United Nations Development Programme (UNDP)

A strong relationship exists between sustainable human development and the growth of shareholder value.

UNDP (*56*)

In support of Kofi Annan's aims of closer UN–industry cooperation, UNDP is planning the Global Sustainable Development Facility (GSDF). This aims to bring together leading corporations and UNDP in an effort to ensure the inclusion of two billion new people in the global market economy by the year 2020 (*56*). GSDF will be established as a separate legal entity outside the UN system and will be "primarily governed by participating corporations and will benefit from the advice and support of the UNDP through a special relationship" (*56*). It will be funded mainly through contributions from the participating corporations. While GSDF's activities will be determined by its participants, UNDP anticipates that these would include developing products and services adapted to the emerging markets of the poor. According to UNDP, involvement of industry in the initiative will bring sponsoring corporations the following benefits: "governmental and institutional contacts at the highest levels... valuable insights into local conditions... worldwide recognition for their corporation... a specially designed logo for the GSDF initiative, highlighting its special relationship with the UNDP" (*56*). As of March 1999, 16 corporations had joined project

discussions. Each of the firms provided UNDP with US$ 50 000 for the project's design and a number had agreed to be represented on a steering committee and to act as special advisors.

Critics allege that the companies (many accused of labour, environmental and human rights abuses) are seeking to greenwash their reputations through association with the UNDP (*57*). Public interest groups assert that "the GSDF joint venture raises the spectre of UNDP programs and priorities increasingly being diverted to serve corporate shareholder interests rather than those of the poor" (*58*). It has also been argued that the GSDF dodges a number of UNDP's own fund-raising guidelines (*59*). The guidelines prohibit donors from advertising their ties to UNDP, as this might imply UNDP endorsement of their goods, and stipulate that donors' "past and present operations must not be ethically, socially or politically controversial." Apparently these conditions were not applied in the case of the GSDF. One columnist has argued that initiatives such as the GSDF will exacerbate the UN's dependence on fickle donors while threatening its integrity and independence (*60*).

United Nations Children's Fund (UNICEF)

UNICEF claims that it "has the most extensive corporate involvement of any single UN body" (*61*). Many of its partnerships are limited to fund-raising and mutual image enhancement but UNICEF is also involved in a number of health sector GPPPs. The Global Vitamin A Partnership provides one example. This partnership includes WHO, US Agency for International Development (USAID), Canadian International Development Agency (CIDA), United Kingdom Department for International Development (DFID) as well as companies which fortify foods — such as Kellogg's, and Procter & Gamble (*62*).

Despite, or perhaps because of, UNICEF's prodigious engagement in public–private partnerships, UNICEF's Executive Director, Carol Bellamy, acknowledges that "it is dangerous to assume that the goals of the private sector are somehow synonymous with those of the United Nations, because they most emphatically are not" (*63*). She urges UN agencies to "carefully and constantly appraise their relationship" with private businesses motivated by profit. This entails "identifying organizations whose behaviour, on balance, shows evidence of a willingness to exercise corporate responsibility." Bellamy is also emphatic that the relationship should not be focused solely on money as industry's comparative advantage may lie in knowledge and experience.

World Bank

Priority will be given to leveraging our finance and advice by partnership with others — thus developing a more selective approach to our business.

World Bank (*5*)

The World Bank has long advocated the need for enhanced participation by the private sector in national development. A recent World Bank discussion paper re-affirmed that "there is a growing recognition that the private sector has a direct stake — along with governments, the civil society, and donors — as a partner for development" (*5*). The World Bank reasons that if national development planning fails to include private sector input, it "would severely erode goodwill". It also contends, in line with the UN Secretary-General, that there has been a paradigm shift. "We are moving from a world in which the state had sole responsibility for public good and business maximized profits independently of the interests of society at large, to a world where success depends on the close synergy of interests among business, civil society and the state" (*64*). Specifically, the role of industry has expanded into domains traditionally held by government, which entails not only increased responsibility toward the community but also a more explicit recognition that the interests of the firm and society are intertwined. The World Bank views GPPPs as an "emerging development methodology;" an approach to development which aims to modify the market.

Among the stated reasons for the World Bank's interest in public–private partnerships is the potential that they offer for leveraging its finance and advice. Among the activities supported by the World Bank is a three-year initiative to establish an informal global network of business, civil society organizations and state entitled Business Partners for Development (BPD). Through support and analysis of a number of selected partnerships, the BPD aims to learn lessons so as to foster more and more successful partnerships. As such, the initiative, will provide "a powerful additional instrument for the World Bank's advisory services to governments, particularly as they relate to social consequences of privatization" (*65*). Hence, from the World Bank's perspective, successful GPPPs provide another means to ameliorate the negative effects of its privatization policies.

World Health Organization (WHO)

We need open and constructive relations with the private sector and industry.

Gro Harlem Brundtland, WHO Director-General (*66*)

Gro Harlem Brundtland has suggested that a strategic objective of WHO is "to be more innovative in creating influential partnerships" because the "broad health agenda is too big for WHO alone" (*67*). A WHO press release argued that through partnerships "we can enhance significantly our ability to mobilize social, political and, therefore, financial support for health development and international health cooperation" (*68*).

A WHO Working Group identified a number of issues that must be addressed in developing partnerships with the corporate sector so as to ensure WHO's reputation as an impartial holder of health values (*3*). This included the articulation of WHO policy regarding the particular industry and the

individual company, as well as considering the appropriateness of the proposed activity. In terms of individual activities, the Working Group was concerned that procedures be established to ensure that real or perceived conflicts of interest are avoided, in particular that: "(a) final normative decisions are free from undue influence; (b) industry funding is not used for salaries of staff involved in normative decisions; (c) consultations and other normative activities never have their majority financing from the concerned industry." How feasible it will be to follow these procedures in practice will be of importance to the outcomes of partnerships with the private sector.

The Working Group also outlined the following risks inherent in partnering with the corporate sector: WHO's reputation as impartial holder of health values may be tarnished by association with certain products; WHO's judgement on a particular product or service may be impaired due to financial considerations and the relationship with sponsor; and WHO involvement with a specific company is perceived as acceptance of unhealthy products, etc. (*3*). In June 1999, WHO issued draft and provisional guidelines governing its collaboration with the private sector; these included the proposal that future collaboration with commercial entities would be subject to review by the WHO Ethics Committee and a newly established Committee on Private Sector Collaboration (*4*).

As part of its partnership strategy, WHO has established a Working Group with pharmaceutical industry representatives. According to WHO, the group will attempt to overcome obstacles to drug access "through improved cooperation between the public and private sectors" (*69*). WHO has entered into a significant number of GPPPs and the great majority of the health partnerships described in part II of this article (*70*) have some degree of WHO involvement.

United Nations Joint Programme on HIV/AIDS (UNAIDS)

UNAIDS is itself an interagency partnership of its seven co-sponsoring UN agencies. Its strategic approach is based on partnership and includes a corporate sector initiative which seeks corporate funds and involvement in UNAIDS activities.

UNAIDS has joined in a number of health GPPPs, including some which are loose coalitions[c] and others which are more tightly governed. The last-mentioned includes the UNAIDS HIV/AIDS Drugs Access Initiative (also known as Bridging the Gap), which was launched in November 1997. During the two-year pilot phase, four developing countries agreed to improve their health infrastructure to ensure the effective distribution and use of HIV/AIDS related drugs, while participating pharmaceutical and diagnostic companies were to subsidize the purchase of these drugs (*72*). Under the scheme, a national HIV/AIDS drugs advisory board was to be established in each of the pilot countries and the pharmaceutical companies were to establish and fund a non-profit company to act as a clearing house for drug orders and imports. UNAIDS was to provide US$ 1 million for, among other things, oversight of the advisory boards. UNAIDS asked each company to donate US$ 25 000 "in each pilot country to help fund an independent body that would buy AIDS drugs at steep discounts and closely monitor their administration to avoid misuse and theft" (*72*).

UNAIDS officials found that "while sympathetic to the problem, the companies were uncomfortable" with introducing tiered drug pricing in African countries. In the opinion of UNAIDS, "it appeared that the world drug industry was principally concerned with protecting huge AIDS drug profits in the US and Europe" (*73*). The first company to join the partnership was Glaxo Wellcome, which lowered prices of AZT (zidovudine or Retrovir) by about two-thirds for Uganda and Côte d'Ivoire in June 1998. Critics suggested that this act of apparent generosity was linked to the fact that the patent on AZT is to expire in 2005 and that the company wanted to maintain sales (*74*). By mid 1998, Bristol–Myers Squibb, Organon Teknika, Glaxo Wellcome, Hoffman–La Roche, and Virco NV were all partners in Bridging the Gap.

In 1998, UNAIDS entered into a partnership with the Female Health Company in an effort to make female condoms more readily available in developing countries (*75*). The partnership consists of a preferential pricing agreement negotiated between UNAIDS and the company, for use in public sector programmes in developing countries. While the condom is sold for between US$ 2–3 in the industrialized world, under the agreement it is sold for US$ 0.50–0.90 in participating countries (*76*). In phase one, during 1998, the partnership covered 16 countries. Phase two, which began in 1999, aims to expand coverage of the programme dramatically.

A more prominent GPPP (Securing the Future) was announced by UNAIDS on 6 May 1999, with Bristol–Myers Squibb making a commitment of US$ 100 million over five years to improve HIV/AIDS research and outreach in Botswana, Lesotho, Namibia, South Africa, and Swaziland. This represents a partnership between Bristol–Myers Squibb, governments, UNAIDS, the Harvard AIDS Institute and a number of schools of medicine. It is not clear what role UNAIDS will play. Although Bristol–Myers Squibb produces three AIDS drugs, the partnership does not include drug donations but will fund research trials, the training of physicians and provide support via NGOs to improve prevention and treatment programmes. The partnership will "complement the broader efforts of governments" (*77*).

[c] In an effort to coordinate corporate responses to the AIDS epidemic, UNAIDS has played a key role in establishing the Global Business Council on HIV/AIDS which was launched in October 1997. The Council is a separate, independent body composed of a group of major corporations and business associations with which UNAIDS works closely (*71*).

Global business

The role and influence of GPPPS in the global business arena is summarized in Box 2.

Box 2. **Industry's interests in global public-private partnerships**

1. **Increased influence in the global arena** — affords opportunity for involvement in the articulation, interpretation and implementation of global rules governing trade, health standards and reform of the UN.
2. **Increased influence at the national level** — the use of United Nations system to gain access to policy-makers, institutions, information, etc (including proximity to regulatory process).
3. **Direct financial benefits** — tax breaks; market identification, development, penetration and manipulation.
4. **Brand and image promotion** — increased global recognition; improved image through association with United Nations.
5. **Increased authority and added legitimacy through association with UN.**
6. **Enhanced corporate citizenship.**

International Chamber of Commerce (ICC)

There is no intention on the part of business to usurp the democratic function or to dictate to the international organizations.

Maria Cattaui (*43*), Secretary-General, ICC

ICC consists of over 7000 member companies and business associations in more than 130 countries. During 1997 and 1998, ICC embarked on a strategy to enhance its visibility and influence at the global level and to become "the" voice of business vis-à-vis the UN (*78*). Former President of ICC, Helmut Maucher, was concerned that the "power of world business" has been "poorly...organised on the international level to make its voice heard" (*54*). Consequently, ICC established, in its words, a "systematic dialogue with the United Nations" (*79*) in an effort to redress this perceived threat to its interests.

As part of its strategy, ICC conceived the Geneva Business Partnership (*43*). Established in 1998, it enabled 450 business leaders to meet with representatives of international organizations so as to determine "how to establish global rules for an ordered liberalism" (*54*). Among the activities organized during the Geneva Business Partnership were a series of lunches between ICC delegates and heads of international agencies, including WHO, WTO and the ILO. These were open neither to the press nor public.

The Corporate Europe Observatory argues that the interests of ICC in seeking a partnership with international organizations are threefold: to gain control of global rule setting and influence global regulatory institutions; to prevent proactively the institutions from taking an anti-business stance; and to gain legitimacy from association with the respected UN agencies (*54*).

GPPPs and health regulation

As businesses have grown and consolidated and their transactions have become global, industry has made a concerted effort to participate in public policy agenda-setting and policy formulation through international organizations, so much so that observers have referred to the "privatization" of the UN (*80*). In the health sector there is an increasing move towards the globalization of pharmaceutical regulation, for example through the European Union's centralized drug approval system. While the increase in international regulatory cooperation undermines national regulatory sovereignty, some argue that the loss in autonomy has been offset by gains in effectiveness and efficiency of government regulation (*81*). However not all countries are convinced that globally agreed rules act in their favour. In 1999 disputes occurred between the pharmaceutical industry, the US Administration and South Africa, whose government asserted its right to license local manufacturers to make anti-HIV/AIDS medicines unless the major drug companies voluntarily reduced their prices (*82*).

GPPPs and image promotion

A more immediate benefit of GPPPs to business lies in the realm of public relations, image enhancement and brand development. Business seems to be convinced by research which suggests that consumers faced with identical products will choose the brand they recognize (*83*). Consequently, companies are keen to project their brand and to create a favourable public image. Merck, which sponsors the Mectizan Donation Program, acknowledges that "... the programme has served to enhance Merck's corporate image and increase recognition of Merck's name, and helped build relationships and alliances between its key constituents" (*84*). Public relations events have included a gala dinner at the UN and a major feature in the *New York Times*. The donation may also have given the company an opportunity to present a caring face to WHO and the international community of public health officials. In May 1994, the WHO Director-General ruled that a Merck spokesperson could address the World Health Assembly, the first time in history of the Assembly that a corporation was permitted to participate (*85*).

Box 3. **Bilateral agencies' interests in GPPPs**

1. Tap resources for international development.
2. Facilitate direct opportunities for national industries and companies.
3. Improve operating environments for national industries and companies.
4. Bolster influence within recipient country.
5. Bring private sector efficiency into public sector bureaucracy.

Bilateral organizations and OECD governments

Many bilateral organizations are beginning to see the potential advantages of GPPPs (Box 3) and actively to seek collaboration with industry. USAID's *New Partnership Initiative* (1995) sought specifically to strengthen its work with small businesses; moreover, USAID is also active in a number of global-level health GPPPs, such as the Global Vitamin A Partnership. DFID argues that partnership is good for business and it "is keen to develop a different way of working in partnership with the private sector which can play a key role in poverty alleviation" (*6*). DFID suggests that three types of partnership models are beginning to emerge.

- Those which improve the operating environment for business. In this type of partnership, business identifies the key legislative and regulatory reforms which would result in a more favourable investment climate, and DFID facilitates access to government officials and provides technical assistance to assist recipient countries with the envisioned reforms.
- Those which strengthen the socioeconomic environment through investment in social infrastructure so as to create more healthy employees or provide new market opportunities (e.g. in Bangladesh DFID supports an initiative by the local private sector to improve the health care of women workers in textile factories).
- Those which involve the development of new products and business opportunities with developmental applications. "DFID is prepared to share the risks of these developments where they would either not occur or would be less efficient without the Department's involvement. For example, early talks are underway between DFID and research-based pharmaceutical companies in the United Kingdom, on working together to develop new approaches to combat malaria" (*6*). DFID policy statements emphasize partnership initiatives that involve DFID affiliation with private companies, and although mention is made that these public–private partnerships may involve international agencies, there is little discussion of how these relationships will be pursued (*7*).

The role of bilateral organizations has sometimes been crucial in the establishment of GPPPs. Thus Louis Currat, formerly with the Swiss Agency for Development and Cooperation, was instrumental in chairing informal discussions between industry and public officials while the Medicines for Malaria Venture was being established (*29*).

Recipient countries[d]

Little is known about the perspectives of governments in low-income countries regarding the trend toward public–private health partnerships, although officials in ministries of health have made appreciative statements when they have been on the receiving end of drug donations or tiered pricing discounts. With respect to the UNAIDS Bridging the Gap partnership, the Ugandan Minister of Health expressed his support, noting "we warmly welcome this initiative" (*72*). Similarly, the Egyptian Minister of Health hailed SmithKline Beechham's donation of Albendazole as an "important public–private sector initiative that promises to stimulate enormous progress in our efforts to eliminate lymphatic filariasis globally" (*86*).

However, when it is perceived that due process has not been observed or when partnerships have been seen to exclude ministry officials, reactions have been less favourable. After the recent launch of UNAIDS/Bristol–Myers Squibb's Secure the Future partnership, the governments of both Namibia and South Africa initially rejected the partnership claiming that they had not been consulted in its design as they had only been represented by academic institutions (*87*). Questions were also raised about the ethics of conducting clinical trials in Africa where the drugs will be unaffordable, and the training of African physicians in the US on drug regimens, methods and equipment that are unavailable in Africa (*74*).

Even where recipient ministries are more fully involved, it is conceivable that the availability of relatively large amounts of external resources for partnership programmes, initiated at the global level, will have a number of potentially negative consequences. Initiatives may divert resources to health problems considered of lower national priority and these may create or exacerbate internal rivalries for control over funds and other resources. Many partnerships, particularly those that are product-based, depend on major inputs from recipient countries (e.g., drug distribution, infrastructure development, training, etc.). For example, in the United Republic of Tanzania, as one consequence of the donation of azithromycin by Pfizer and Co., the head of preventive services in the ministry of health has been seconded to the trachoma control programme so as to oversee the donation programme. For example, in the case of EPI the vaccine cost per fully immunized child is estimated at US$ 1.50, whereas the full cost (including salaries, facilities, training, etc.) is US$ 15.00 (*88*). Not only does this raise questions concerning the rational allocation of counterpart funds, but also how effectively initiatives are likely to be implemented where national ownership is lacking. The donation of the combination antimalarial drug Malarone by Glaxo Wellcome to Kenya has raised a number of dilemmas and challenges for the government (*89*). First, there are claims that the drug by-passed the routine regulatory processes and it appears on neither the Kenya essential drug nor the WHO Model List of Essential Drugs. Second, the lack of legislation preventing private sector use coupled with the likelihood that public sector workers will use Malarone as a first-line

[d] While the term low-income may be more value-neutral, we use the term recipient in that this characterises the role of low-income governments in most GPPPs.

treatment will make it difficult to prevent drug resistance from developing. A Donor Coordination Group was recently initiated by Merck & Co. to identify ways that companies could collaborate in reducing the burden placed on ministries of health involved in these programmes (*90*).

Box 4. **Recipient's interests and concerns regarding GPPPs**

1. Appreciative of additional resources targeted at select health problems and opportunities to strengthen existing infrastructures.
2. Ministry of Health officials concerned about initiatives in which they are not sufficiently involved.
3. There is concern that GPPPs may divert domestic resources from national priorities, or other needs.
4. Donation programmes may provide more opportunities for corruption or leakage from the programme into other sectors.

Finally, it remains to be seen how developing countries will react to the trend of shifting technical and normative discussions from WHO forums (where developing countries have some representation) to governing boards and technical advisory committees of the GPPPs (where it appears that they are less well represented).

Conclusions

This article sets the background and context to a changing landscape of collaboration within international health and development. Where international health was once dominated by the public sector through UN agencies and bilateral organizations, with some NGO participation, today there is greater pluralism — more actors, and much closer involvement of the corporate sector. One of the most recent, and arguably most significant, areas of collaboration is through what we have termed GPPPs — forms of organization which transcend national boundaries, and bring together a number of different partners to pursue particular health goals.

There are many reasons why more organizations are embarking on health partnerships at both global and national levels. Shifting ideologies and trends in globalization have highlighted the need for closer global governance, an issue for both private and public sectors. We suggest that at least some of the support for GPPPs stems from this recognition, and a desire on the part of the private sector to be part of global regulatory decision-making processes. There is also increasing recognition that the actions of one sector or organization reverberate on others, and searching for common ground may be fruitful and lead to "win-win" interactions in an increasingly interdependent world. This has provided a forceful justification for the creation of public–private partnerships.

However, while there are many positive aspects to these new GPPPs, there is also a great deal of uncertainty and some cause for concern. We have argued that public and private sectors are driven by differing ethos and principles, but how these unique attributes will be affected by partnerships remains to be seen. Are all partners equally influential in all situations and do differing levels of influence matter where all are allied in a common purpose? The under-resourced UN's resolute drive towards collaboration with the private sector derives, at least in part, from a position of financial weakness. This, coupled with the perception that many UN agencies are over-bureaucratic and inefficient, may undermine UN influence within GPPPs. The nature and extent to which the act of partnering with the commercial sector transforms the perceived authority and neutrality of the multilateral actors is too early to judge, but undefined guidelines and limited public disclosure of information surrounding GPPPs do raise questions. For example, recipient country partners may be excluded from GPPP decision-making. This type of omission is likely to be exacerbated as avenues for effective national interest articulation through UN channels are circumscribed in favour of mechanisms for global governance through GPPPs. In part II of this article we address some of these concerns, suggesting a conceptual framework for describing GPPPs, and raising a number of questions for future governance of GPPPs concerning representation, accountability, competency and resources. Finally, we suggest that research in this area is essential. ■

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Résumé

Partenariats mondiaux public-privé : partie I – un nouveau développement dans le domaine de la santé ?

La prolifération des partenariats public-privé est en train de remodeler rapidement le paysage sanitaire international. Cette première partie d'un article en deux volets décrit la nature multiforme du partenariat et examine les ambiguïtés, tant sur le plan de la définition que sur le plan conceptuel, qui entourent ce terme. Après avoir défini les partenariats mondiaux public-privé (PMPP) en faveur du développement sanitaire, nous analysons les

facteurs qui ont conduit au rapprochement des acteurs du secteur public et du secteur privé et nous examinons les conséquences de la tendance aux partenariats entre les organisations des Nations Unies (y compris la Banque mondiale) et des entités commerciales dans le secteur de la santé. Des facteurs génériques tels que la mondialisation et la désillusion vis-à-vis des Nations Unies, et des facteurs spécifiques au domaine de la santé, comme l'échec commercial du développement de produits contre les maladies rares, sont examinés. L'article passe en revue, dans l'optique des partenariats public-privé, les intérêts, politiques, pratiques et préoccupations des organisations des Nations Unies, des partenaires du secteur privé à but lucratif, des organisations bilatérales et des gouvernements des pays à faible revenu. Alors que les PMPP apportent des ressources bienvenues pour faire face aux problèmes de santé internationale, nous relevons un certain nombre de questions concernant ce nouveau type d'organisation. La partie II, qui sera publiée dans un prochain numéro du *Bulletin*, présentera un cadre conceptuel pour l'analyse des PMPP dans le domaine de la santé et examinera les problèmes qui pourraient se poser.

Resumen

Fórmulas de asociación mundiales entre los sectores público y privado: parte I - ¿un nuevo avance en el campo de la salud?

La proliferación de formas de colaboración entre los sectores público y privado está reconfigurando rápidamente el panorama sanitario internacional. En este artículo (parte I de dos sobre el tema) se detalla la naturaleza cambiante de esas asociaciones y se analizan las ambigüedades definicionales y conceptuales que rodean esa expresión. Después de definir las fórmulas de asociación mundiales entre los sectores público y privado (FAMPP) para el desarrollo sanitario, analizamos los factores que propician la convergencia de los actores públicos y privados y examinamos las consecuencias de la tendencia hacia la formación de alianzas entre organismos de las Naciones Unidas (incluido el Banco Mundial) y entidades comerciales del sector sanitario. Se analizan factores genéricos como la globalización y las reacciones de decepción ante las Naciones Unidas, y factores específicos del sector de la salud, como los fallos del mercado en el desarrollo de productos ''huérfanos''. Se examinan los intereses, políticas, prácticas y preocupaciones de las Naciones Unidas, del sector privado con fines de lucro, de organizaciones bilaterales y de los gobiernos de paíes de bajos ingresos en relación con las FAMPP. Si bien éstas reportan recursos muy necesarios para abordar los problemas sanitarios internacionales, hemos destacado aquí varios aspectos de la nueva fórmula organizacional que suscitan preocupación. En la segunda parte del artículo, que se publicará en un futuro número del *Bulletin*, se presenta un marco conceptual para analizar las FAMPP para la salud y se examinan los problemas planteados.

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