

# Global Public Health and Innovative Forms of Governance

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## 1. Introduction

The global health landscape is changing, not only in terms of the ways in which globalization affects the spread of diseases but also in terms of how global health is being governed. Over the past 15 years, there has been a proliferation in so called hybrid forms of governance, encompassing public-private partnerships (PPPs) and other forms of cooperation between different types of actors such as states, intergovernmental organisations, civil society, academia and business.<sup>1</sup> Although hybrid governance is also found in a wide range of other issue-areas, notably environmental protection, education and development, it seems that it is especially within the field of global health they have become particularly abundant, influential and sure footed. For many observers of global health, these hybrid forms of governance have therefore themselves become objects of investigation and analysis. In several recent studies into global health governance, it has is been asked: what are the different forms, compositions and aims of PPPs? (resulting in typologies); and how can we reconcile the normative-ethical issues that arise concerning a re-distribution of power, responsibility and accountability, when private actors are involved in global decision-making processes? (Nishtar 2004).

It is surprising that the central subject of investigation has rarely been the question of why the proliferation of hybrid governance has been so strong within the health issue-area. Why are there so many global (and local) PPPs for health? Why has this phenomenon eventuated now? And why is health an issue-area that is apparently so receptive for these types of governance forms in the first place? Several books and articles that can roughly be categorised as addressing issues of *global health governance* hint at the reasons behind this trend, (usually offering a few lines or a paragraph on the emergence of PPPs) although few have thus far addressed these quite critical questions as a central issue.

In 2001, Gill Walt suggested that processes of globalization such as the increased movement of goods, people and ideas as well as increased communication technologies and the marketing of products lie behind the shift towards PPPs. The empowerment of business, greater scrutiny of their activities and ‘disillusion’ with the UN and governments have all made it harder to deny the demand on behalf of business “that it be a partner in discussions on public health”. (HAI Europe 2001: 9). Buse and Walt also refer to three contextual changes that strengthened the perceived need for new governance forms, first, ideological shifts towards neo-corporatism; second, growing disillusionment with the UN and its agencies as well as chronic funding shortages within those agencies; and finally, recognition that “emerging health problems require a range of responses beyond the capacity of either public or private sectors working independently” (Buse/Walt 2000: 550-551). Hein *et al.* suggest

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<sup>1</sup> Throughout this paper, I will mainly refer to Public-Private Partnerships, (PPPs), however the term is used broadly and the alternative “Public-Private Interactions” may be considered more suitable.

that the rise of global health governance can be seen as a consequence of the challenges posed by contrasting policy strategies composed of the broad systems based strategy advocated by the WHO in the declaration of Alma-Ata in 1978, and the dominant neo-liberal approaches from the 1980s onwards which have pushed new actors into the health policy domains (Hein *et al.* 2007). On another slant, Loughlin and Berridge suggest that we should be cautious with presumptions that PPPs represent a new phenomenon at all; there has long been a history of private sector provision of health care and private-actor involvement in health on a international level (Loughlin/Berridge: 2002).

In this paper I will take some of the suggestions made by these and other authors about the reasons behind the proliferation of PPPs for health in recent years and elaborate on them to systematise and separate different levels of reasoning on the unit and systems levels. Any comprehensive explanation of the burgeoning of public-private governance needs to look at both macro- and micro levels, by examining both the changing global realities that provide conditions promoting public-private partnerships as well as the changing motivations of the actors involved.

The paper begins with a description of the rise in prominence of PPPs within the health sector. In the second section of the paper I elaborate on three possible explanations for the rise of PPPs (and hybrid forms of governance more generally) in health, including the historical legacy of private actor involvement in health, the neo-liberal turn in global politics from the 1980s onwards, and actor motivations. In the third, concluding section of the paper I will discuss issue-specific aspects of health that make it a unique issue-area requiring, and supporting innovative forms of cooperation and governance. In this section the impact of the HIV/AIDS epidemic, the role of the World Health Organisation and the role of elite epistemic communities will be discussed.

## **2. Public-private partnerships for health**

There are generally four dimensions by which we can see an increase in the weight that public-private partnerships now carry in global health; first; the sheer number of partnerships that have been established, second, the scope of these partnerships, in terms of geographic reach, their types of activities, and acquired resources; third; the level of organisational sophistication of the partnerships and; fourth, the level of acceptance that they now appear to enjoy. These four aspects will be discussed below, but first a note on the object of investigation.

### **2.1 What are PPPs for health?**

Although there are excellent typologies systematising the different roles, legal status and organisational makeup of PPPs for health, (Buse and Walt 2000; Widdus 2003) confusion still exists over the exact definition of public-private partnerships, their composition and the extent to which they really are new in public health practice (Malena 2004: 2-4). According to the World Health Organisation “ the term public-private partnerships covers a wide variety of ventures involving a diversity of arrangements, varying with regard to participants, legal status, governance, management, policy-setting prerogatives, contributions and operational roles.” (WHO: 2007) By definition of the UN Secretary General’s office, public-private partnerships are “voluntary and collaborative relationships between various parties, both state

and non-state, in which all participants agree to work together to achieve a common purpose or undertake a specific task...” (cited in Malena 2004), and the UK Department of International Developments Global Health Partnerships Project offers a definition along a similar vein as ‘...a collaborative relationship among multiple organisations in which risks and benefits are shared in pursuit of a shared goal (Carlson 2004: 5). These definitions however, leave room for confusion in terms of the roles that the ‘various parties’ should play, or how these ‘collaborative relationships’ differ from any other contractual relationships between state and non-state actors that have existed in the past. Widdus makes the point clear that the term ‘partnership’ has been used “...loosely to include communication, consultation, coordination and collaboration...” as well as the privatisation of health services (Widdus 2003: 235). With rising scepticism of the extent to which joint decision-making really takes place, some now prefer the term Public-Private Interactions (PPIs) to PPPs (HAI 2007). Regardless of the vagueness in definition however, the point to be made here is that increasingly actors from both public and private sectors do work together in organised environments that externally present themselves as belonging to a certain convention of the day; namely that it is both possible and desirable that public and private actors should jointly contribute to the production of public goods. Public-private partnerships are therefore not necessarily a concrete form of organisation, but can be seen as a policy paradigm based on this convention (See Richter 2004: 45).

## **2.2 Quantity**

Despite the variety in types and forms of public-private partnerships and blurred lines of definition, a rapid formation of a large number of PPPs over the past 10 – 15 years can be asserted. In 2003 Roy Widdus reported on over 50 PPPs operating internationally, and by 2005, the International Public-Private Partnerships for Health database, which he managed, listed over 80 PPPs for health with a global focus. Most of the partnerships listed were formed later than 1995.

There are many more PPPs which operate locally and regionally and as yet there is no central data source that comes close to listing them all. Several studies have appeared in recent years which examine the work of public-private partnerships that operate on a small scale or within a specific area of activity. Such studies give an indication of the diversity and range of PPPs that might otherwise rarely receive any attention; this includes partnerships in developed as well as developing countries. For example Raman and Bjoerkman (2004) conducted 16 case studies of public-private partnerships for health on local levels in India, Merz (2005) reported on 14 health product development PPPs based in the USA and Nikolic and Maikisch (2006) review 9 case-studies of PPPs in health sectors in Europe. There are also now several umbrella groups operating that promote and/or assist the development of PPPs, such as PSP-One, a project within USAID that also maintains a database with over 140 health projects that involve the business sector, most of which involve cooperation with government agencies, Non-governmental Organisations (NGOs) and/or UN agencies; the World Economic Forum’s Global Health Initiative, that acts as a coordinating group for private sector participation in health PPPs and the European Partnership for Global Health which acts as a broad strategic platform for health research and partnering. While the formation of prominent large scale PPPs for health seems to have reached a peak around the turn of the century, the number of smaller scale, region specific partnerships appears to be still increasing, although more research needs to be done on the extent of this trend.

### 2.3 Scope

The reach of public-private partnerships has widened not only in terms of their quantity, but also in their quality, this can be discerned in terms of several facets.

First; there is now an astounding range of activities and goals approached by various public-private partnerships, and PPPs seem to be able to follow trends in political and public health priorities. A few examples of the types of PPPs that involve United Nations Agencies today help to emphasize this point. There are a large number of product donation and development PPPs which emerged in the late 1980s to mid 1990s, (e.g. the Mectizan Donation Program, founded in 1987 and the International AIDS Vaccine Initiative established in 1996) and disease focussed PPPs from around the turn of the century (e.g. Roll Back Malaria and the Stop TB Partnership). More recently, PPPs have emerged focusing on pressing issues such as education resources, (e.g. The Health Communication Partnership founded in 2004) and health workers shortages (The Global Health Workforce Alliance, founded in 2006). PPPs are also used for many small specific areas of activity such as hospital and outpatient services.

Second, PPPs have widened their geographical scope. Whereas 'international' partnerships in the 1980s and early 1990s involved mainly service provision in developed countries, or global coordination services, today, PPPs, both global and local, are active in almost every country on the globe. Countries such as India and Thailand have specific government units established for the promotion of PPPs, and even PPPs that always intended to be global in scope have managed to widen the number of countries involved as donors and recipients in recent years. The Global Alliance for Vaccines and Immunization (GAVI) for example has steadily increased the number of countries receiving support since its inception in 2000 and now assists projects in 73 countries. The Global Fund to Fight AIDS, Tuberculosis and Malaria, (GFATM) is active in 136 countries.

Third, PPPs have increasing levels of resources at their disposal. This can be most clearly seen in terms of financial resources, but also in terms of the numbers of expert staff they employ and the social and reputation resources they have gained. The two PPPs mentioned above are prime examples. GFATM has disbursed over \$US7.6 billion dollars in funds to date. GAVI has increased its budget significantly thanks to an increase in funds pledged from donors from US\$93 million in 2001 to \$US 960 million in 2006.<sup>2</sup> This included government as well as non-government sources.

### 2.4 Sophistication

Many PPPs within the health sector have and are undergoing changes in terms of their organisational structure and rules for decision-making. This has come about as many PPPs have transformed from pilot projects to long-term strategy forming organisations. As they become more influential, they are increasingly faced with rising expectations from partners and other stakeholders not only in terms effectiveness, but also fair, just and representative governance, In turn, the level of institutionalisation has increased over time, in which modes of cooperation are regulated through constitutions and the roles of partners are clarified (See Huckel *et al.* 2007). Although no two PPPs are alike, there are striking similarities in what is considered good governance of PPPs and several groups now involve multi-pronged structures with executive boards, technical advisory committees, stakeholder information

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<sup>2</sup> For information of GFATM disbursements see their website at:

[http://www.theglobalfund.org/en/funds\\_raised/commitments/](http://www.theglobalfund.org/en/funds_raised/commitments/) Accessed: 25<sup>th</sup> August 2007.

For information on pledges to GAVI see their website at:

<http://www.gavialliance.org/support/donors/index.php> Accessed: 25<sup>th</sup> August 2007.

contact points etc. Standards begin to form regarding 'good' or appropriate governance structure which act as models for other, newer and smaller PPPs.

## **2.5 Acceptance**

Finally, PPPs seem to be gaining increasing levels of acceptance as vital, stable and even taken-for-granted organisations within of the global health architecture. This is not to say that there isn't considerable criticism and debate about the appropriateness of these kinds of organisations, however, PPPs seem to have gained an increasingly sure footing within global health as the appropriate strategy of the day. The United Nations explicitly promotes closer ties with the business sector to increase effectiveness and efficiency; and in 1993, the World Health Assembly called on the WHO to "mobilize and encourage the support of all partners in health development, including nongovernmental organizations and institutions in the private sector, in the implementation of national strategies for health for all" (WHO 1993). The WHO 2002 Report on Communicable Diseases describes PPPs as contributing to the strengthening of health services and systems, (WHO 2003: 31) and at national levels ever more development agencies and finance ministries have officially promoted the use of public-private partnerships as a strategy for global health in white papers. A statement from the Minister of State for Irish Aid and Human Rights, is a typical example of recent times stating that PPPs are: "a key strategy for the fulfilment of our commitments in the White Paper on Irish Aid and implementation of our policies on Health and HIV. ... Irish Aid maximises the impact of its efforts by working with global health partnerships" (Irish Aid 2007). In developing countries PPPs also appear to have become part of regional strategies, as written in the latest Africa Health Strategy of the African Union, where it is promoted that states "... will also ensure participation of civil society and the private sector in the development and review of national health programs and create a conducive environment for this to happen." (African Union 2007: 23)

Together, these four elements, quantity, scope, sophistication and acceptance indicate that PPPs have become a prominent if not dominant strategy for addressing deficiencies and problems in global health. Both within the WHO and at national levels, they appear to have "become the method of choice to address a large component of international public health efforts" (Reid and Pearse: 2003). However, the desirability of this trend, due to the lack of evidence on the effectiveness of this type of cooperation and the ethical concerns involved with legitimizing private power through cooperation with public entities. A lot of disagreement in this debate can be traced back to differences in opinion of whether the proliferation of PPPs can be seen as a logical, even natural progress towards more advanced global governance, or whether certain ideological shifts, structural changes or historic events have in fact spurred an artificial phenomenon which is neither sustainable nor desirable. Whereas for some observers, powerful actors have steered global governance in a direction where private the private sector has gained bargaining power, for others, PPPs can be seen as a variation of an already long standing dispersion of roles between public and private actors throughout history.

### **3. Reasons for the trend towards PPPs in health**

In this section I will take three contrasting views of the background conditions that have led to the proliferation of public-private partnerships in health. The first, a historical view, serves to highlight some of the new and not-so-new aspects of PPPs against the background of already long standing forms of cooperation in health. The second, more critical view sees the proliferation of PPPs as part of, and as a consequence of, a world-wide ideological shift towards neo-liberalism from the 1980s onwards.. The third view looks at the unit level, seeing PPPs as a consequence of increasing resource interdependence and changing motivations of actors to cooperate in the field of health.

#### **3.1 Public-private cooperation as a historical legacy**

Although often breaking with governance conventions of the past in terms of substantial participation of non-state actors in high-level decision making, PPPs have arisen on the back of a long history of non-state actor participation in health. For some, any analysis of PPPs in health should therefore be conducted with this legacy in mind. Historical views emphasise the need to re-examine “the familiar and taken-for-granted once they are placed in new or seemingly incongruous relationships”. (Loughlin and Berridge 2002: 1). The apparent proliferation of PPPs and extent to which they represent something “new” may be tied up with false presumptions about the roles that public and private actors have played (and the ways in which they have interacted), in the past. If we are to accurately explain change, it is first necessary to question what is new and whether current trends have been gradual or sudden. Although historians have noted that “that the sheer scale and complexity of developments (in global public health) preclude any easy synthesis” (Loughlin and Berridge 2002: 21) there are at least four key assumptions or perceptions that have arisen in terms of the current proliferation of PPPs that need to be carefully considered:

First, any premise that health has primarily been the responsibility of the state, and is only now, (in the wake of the effects of globalisation) moving from away from state into private hands should be re-examined to adequately take into account the role played by the non-state sector in health throughout history and today.

Public health projects have a long history of being led by individuals, churches or community groups, before health care was standardised as a public responsibility within welfare states. For example early public health actions in the 19th century to clean up American cities were led by civil leaders and women’s groups, and in England, the pre World War Two national health service was a mix of public and private actors working together. In many countries, hospital services run by churches and other charitable groups pre-date those run by the state and even now non-state actors play a large role in the provision of health services in developing countries, even without being part of any public-private partnership or receiving funding from public sources. Private for-profit and non-profit sectors are highly active in developing countries and are the preferred health care providers in many situations. Bustreo *et al.* cite a project that takes treatments for two of the most debilitating health problems in developing countries, diarrhoea and respiratory tract infections as an example. In a sample of 38 countries, the rates of treatment for those diseases from the non-state sector were between 34 and 99 percent. (Bustreo *et. al* 2003, citing Gwatkin *et. al* 2000). It can therefore be misleading to think that within the health sector, provision has always, and will therefore

continue, to be provided primarily by the public sector. In the context of global interventions on health too, non-state actors have played vital roles. Immunisation campaigns in the developing world were conducted with support from high profile NGOs such as Rotary International and the Red Cross as well as involving volunteer groups of teachers, religious leaders, journalists and police (Cueto 2004: 1868).

In Europe, health has developed into a right of citizenship, connected with principles of solidarity and wealth re-distribution (such as state-run health insurance) (Kickbusch 2004: 1). “This historical dimension with its roots in a view of health as a means of empowerment for individual citizens and a responsibility of the state for the health of the public is critical to any discussion of European values in health and health policy.” (Kickbusch 2004: 1). McKee writes that within Europe and other western societies, the “deeply held beliefs that the state has a responsibility (for health)... implies an acceptance of policies that seek to enhance population health” (McKee 2002: 181). This includes interventions within the state, and when necessary on a global level. An onus on the state as being responsible for health has broadened to have global relevance, but in reality a large role continues to be played by non-state actors. Against this historical backdrop, PPPs may be seen as a method through which expectations on the state to ensure the provision of adequate health care can be met by incorporating private activities into a publicly approved and controlled arena.

Second, any perception that the era of the GATT institutions poses a *new* challenge to global health (the risk of health being overshadowed by trade interests) should be re-examined to take into account the fact that throughout history public health concerns have long struggled to carry any weight against profit, expansion and commerce. Early examples are the International Sanitary Conferences; early instances of state-state negotiations for the management of a particular trans-border threat, namely the spread of disease through the transportation of goods. Commerce, trade and economic competition dominated and eventually weakened these negotiations” (Loughlin and Berridge 2002: 7). Rarely were the agreements that were reached by delegates actually ratified by the governments represented when trade interests were placed at risk. Several key issues concerning clashes between trade and health regimes today can be interpreted as part of the *ongoing* conflict between trade and health regimes, including controversies over the World Trade Organisation TRIPS agreement to promote investment into research of new technologies including medicines, and structural adjustment programmes (now no longer advocated) from the World Bank for the purpose of promoting trade for economic development. Against this historical backdrop, PPPs can be seen as a strategy to overcome long conflicting policy regimes and to negotiate exceptions to dominant trade rules.

Third, any perception that PPPs emerge because large philanthropist groups have turned their attention to health only in recent years should take into account the near century old tradition of foundation contributions to large scale health projects. From the 1920s onwards private donors from the United States such as the Rockefeller and Ford Foundations have been especially active. For example the League of Nations Health Organisation (LNHO) drew between a third and a half of its budget from the Rockefeller Foundation at certain times (Weindling 1995: 139). The LNHO’s narrow focus on technology transfer, scientific universalism and standard setting (i.e. in biological information and epidemiological research methods) during this era demonstrates how personal and financial links, and a growing body

of expertise and personnel transfer, may have steered strategies in certain directions. Today, several large scale PPPs have been founded and supported by initial pledges from foundations such as the Bill and Melinda Gates Foundation and the Ted Turner Foundation, once again promoting specific science based strategies which have been sometimes praised and sometimes criticised for their approach. Against this historic backdrop, PPPs today, a large number of which include UN-Agencies as partners, can be seen as a reinvigoration of private donor involvement that has actually been around since the founding of the United Nations and its predecessors, but was less visible during the 1970s and 1980s (Kimble 2004).

Fourth, any apparent ‘jump’ in the number of activities played by non-state actors, especially those from civil society sectors and expert communities might be masked by the previously low-profile yet steadily advancing role they have played in global health policy over the last 50 years. Non-governmental organisations (NGOs) have long been recognised as a supplier of public services and involved with agenda setting and policy implementation, but they have also been active in steering the direction of health and other development policies. At the inception of the World Health Organisation, provisions were already in place to ensure access to the knowledge resources of NGOs. Echoing Article 71 of the UN Charter, Article 71 of the World Health Organisation states that “the WHO may make suitable arrangements for consultation and cooperation with nongovernmental organisations (NGOs) in carrying out its international health work.” “Indeed, national as well as international NGOs were an important voice in the 1945 UN Conference on International Organization, at which the shape of the new postwar machinery of intergovernmental organization was discussed” (Loughlin and Berridge 2002: 20).

While civil society cannot be categorised as a distinct sector, it can be observed that non-for-profit entities have played a variety of roles such as contributing technical expertise to policy development,<sup>3</sup> making global policy processes more accessible to individuals through information dissemination and promoting public accountability (Loewenson 2000: 5). The tendency to define civil society and NGOs as comprising only advocacy or protest groups increases the perception that NGOs activities have really only taken off since the era of media campaigns. However, there has actually been long standing cooperation between states, intergovernmental and non-for-profit organisations. For example the WHO Civil Society Initiative names a 50 year long history of collaboration with professional associations such as the International Water Association and the International Council of Nurses. (WHO 2002: 18-19).

Although the acceptance of NGO activities has varied in different cultural regions, the high level of involvement of NGOs in UN-Projects such as the Framework Convention for Tobacco Control and United Nations Joint Programme on HIV/AIDS (UNAIDS) can be seen as an extension of the existing formal ties already awarded to NGOs under consultation. UNAIDS has in turn been described as a ‘pilot institution’ for further multi-stakeholder initiatives, such as PPPs (Martens 2007: 29).

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<sup>3</sup> For example the WHO Civil Society Initiative names a 50 year long history of collaboration with the International Water Association which provides a network of “around 7000 water professionals in over 130 countries.

The above examples highlight just four aspects that demonstrate how important it is to question common assumptions about global health governance today. The historical viewpoint does not necessarily always view PPPs as a natural progression of developments in time. Rather, it points out that PPPs sometimes represent newly modelled variations of cooperative arrangements that have existed in the past or can be seen as possible solutions to long standing conflicts between different regimes. To the extent to which they *are* new, PPPs can be seen as a reaction to demands on state actors to control more aspects of public health than they have done in the past, while NGOs and other expert communities may be seeking formal recognition of the roles that they have long been playing.

### **3.2 A Neo-liberal turn – system level changes**

Public-private partnerships have been the subject of considerable scrutiny not only amongst academics and philosophers, but public health practitioners (Fort *et al.* 2004, Kim *et al.* 2000 Richter 2003). This is because they seem to indicate an entrenchment of a power shift towards business and other resource rich actors, who enjoy power advantages in cooperative arrangements separated from the “more discursively sensitive UN bodies, whose anchoring in parliamentary structures ensure at least some form of a forum of “political will-formation”” (Thomas and Weber 2004: 192). For some the emergence and increase in influence of the public-private partnership paradigm has arisen as part of, and as a consequence of, a global ideological shift towards neo-liberalism. The global health governance landscape has taken a corporatist turn which has led to first, a failure to address key social determinants of health, second, the possible enhancement of business agendas, third, a large influx of resources towards narrow, ‘popular’ or profitable programmes and fourth may leave many countries with failing health systems.

Thomas and Weber (2004) take the declarations made at the Alma Ata in 1978 and the G8 summit in Okinawa in 2000 as ‘signposts’ for two very different strategic approaches towards global health. The Declaration of Alma Ata followed a consensus that the World Health Assembly should be the central forum for global health policy and the WHO the key standard setting organisation. Health as a human right was a central focus and goals were set to provide needs-based health care focusing on system wide development and comprehensive primary health care (PHC). The Okinawa G8 Summit in 2000 is indicative of a very different era during which funding mechanisms independent of the UN System were advocated and the focus was set on reducing the burden of specific ‘high-profile’ diseases with quantifiable aims. Public-private partnerships came to be seen as appropriate policy-responses in the context of globalisation. What happened within these two decades for such different policy strategies to emerge?

There is no shortage of statistics that highlight the widening gap between high and low income countries in terms of vital health indicators and it is not surprising that increasing poverty and strong correlations between poverty and poor health lead to questions on the role that economic globalisation has played in leading to this state. Many authors suggest that processes of globalisation have led to a widening in the gap between wealthy and poor and unequal access to the resources required to maintain good health. Porter *et al.* refer to “...evidence that adjustment to fundamental social changes (...) has been worsened by the

introduction of particular policies by the aid community, such as structural adjustment and other forms of liberalisation, without sufficient consideration of the social impacts” (Porter *et al.* 2002: 185). Ranson *et al.* have elaborated on the view that there is an inherent tension between trade and health interests and that in many countries trade liberalisation has ‘increased income distribution inequalities and worsened the opportunities for access to medicines, particularly for the poor’ (Ranson *et al.* 2002: 39).

It has been claimed that following stagnating budgets of the WHO in the 1970s and 1980s the global monetary and economic institutions became increasingly influential in global health. Policies of the World Trade Organisation and the World Bank emphasised the need for economic development in order to achieve health aims, emphasising correlations between increasing per capita incomes and a range of other health determinants such as education spending, sufficient earning power to avoid deprivation of food, nutrition and shelter; female literacy and women’s rights and social and civil rights (Bloche and Jungman 2007: 252). In 1993, the World Bank published its influential report “Investing in Health” which is seen as point in which neo-liberal approaches came to dominant global health policy. The state was meant to withdraw its influence on markets and reduce spending. Policy advice was given to developing countries from donor countries and the World Trade Organisation to shift from health systems approaches to privatisation and user pay services (Brugha and Zwi 2002: 65). This led to a steady trend towards further privatisation of health service provision in some countries. “At independence the private sector in India had only eight percent of health care facilities but recent estimates indicate that 93% of all hospitals, 64% of beds, 85% of doctors, 80% of outpatients and 57% of inpatients are in the private sector” (as cited in Raman and Björkman 2004: 76)

During the 1990s certain policies such as Structural Adjustment Programmes and measures to protect intellectual property and encourage product research and development through the trade-related intellectual property rights (TRIPS) agreement were heavily criticised as restricting access to vital products and services. Both the World Health Organisation and the World Bank adjusted their policies recognising interventions for health as exceptional cases. However, rather than shifting back to health systems approaches, the 1990s saw a re-vamping of the global health policies of donor states and the global economic institutions towards advocating market ‘modification’ through increased cooperation with the wide range of stakeholders, including those from the private sector, for the effective provision of essential services. “Importantly, the PHC strategy was modified/derailed before it got going. Selective primary health care (SPHC) replaced the original Primary Health Care concept as an adjusted term in terms of policy response, this meant a focus on specific interventions, such as immunisation and oral rehydration, rather than an integrated approach to social transformation and community empowerment.”(Thomas and Weber 2004: 193).

Public-private partnerships can therefore be seen as a policy paradigm based on the presumption, that given the current roles and distribution of resources amongst various actors, such as states, development agencies, NGOs and business, it is logical or appropriate to enter into cooperative arrangements based on mutual trust and benefits (See Richter 2004: 45). Critical perspectives may doubt these actor motivations but even more crucially question the driving forces which have led to such a distribution of resources and power in the first place (See Richter in HAI 2001: 12). The dominant neo-liberal policies of the 1980s and 1990s led

to certain actors have acquiring an over-proportion of financial and knowledge wealth which has awarded them advantages in bargaining power. The promotion of PPPs amongst powerful states and transnational corporations both accepts and compounds these advantages.

### **3.1 Actor motivations and interdependence – unit level changes**

The most commonly examined explanations for the proliferation of PPPs in health are concentrated on actor motivations. In short, an increasing awareness that achieving solutions to global health challenges are beyond the capacity of any one actor alone (e.g. the state) has led to the realisation that it is necessary to pool resources, (financial, technical, social) in order to achieve common goals. In addition, advances in communication technologies have allowed for more intense interaction and sharing of ideas, allowing for broader participation and reducing the logistical barriers to multi-actor cooperation (Buse and Walt: 170).

Several observers take actor-motivation explanations as the most obvious reason behind the increase in willingness to participate in PPPs and multi-stakeholder initiatives for health. They cite both dissatisfaction with current global institutions and negotiating processes, as well as optimism that new public-private arrangements will allow for broader representation of neglected citizen's groups and more efficient problem solving as motivating elements. For example Martens in a report on the general proliferation of multi-stakeholder initiatives writes that: "The root causes of this general tendency are manifold and include a... general dissatisfaction on the part of governments, international organisations and NGOs with the agonizingly slow pace of the cumbersome global negotiation process..." (Martens 2007: 4). Buse and Walt suggest that partnerships housed outside of the UN bureaucracy were viewed as "a way of getting things done, and where industry is involved, getting things done efficiently" following negative perceptions of UN effectiveness. (Buse and Walt: 173). Nishtar suggests that: "The need for public-private partnerships arose against the backdrop of inadequacies on the part of the public sector to provide public goods on their own in an efficient and effective manner, owing to lack of resources and management issues." (Nishtar 2004: 1) Many of the large scale PPPs located on the periphery of the UN system allocate formal decision-making rights to interest groups such as people whose lives are directly influenced by disease. This has been seen as a positive step forward compared with intergovernmental institutions, which have been criticised for the many degrees of separation that lie between executive decision-making and individual citizens.

Some level of common goals is said to be a prerequisite for the establishment of partnerships and in general the aims of disease eradication and increasing life expectancy are (at least rhetorically) accepted as desirable on behalf of states, international organisations, civil society organisations and business actors alike. If relevant actors are convinced that placing their resources at the disposal of other partners offers the most promising approach towards achieving global health aims, then PPPs will be seen as a viable and legitimate option. (Rittberger *et al.* 2007) Still, the motivations of actors can differ considerably. Several of the larger PPPs for health have a founding history that points towards specific actor initiatives as the reason behind their formation. GAVI for example has been cited as having been founded as a revived version of the Children's Vaccine Initiative following a financial commitment from the Bill and Melinda Gates Foundation (See Muraskin 2004: 1923), and the Global Fund to Fight AIDS Tuberculosis and Malaria was founded following the initiative of G8 members

and few large scale pledges of motivated donors. The real processes that lead to the formation of PPPs are of course complex, but the role of leading actors or groups of actors in spurring the pathways towards the formation of PPPs is important (Bartsch 2002: 447). The motivations of actors to engage in public-private partnerships can vary according to relative power positions, health goals, own aims and responsibilities as well as preferred methods of approach.

The reasons why business actors become involved in PPPs are the most well analysed of all stakeholder groups. Transnational corporations and other large private donors involved in global health set out to gain from the opening or securing of market opportunities, reputation and image enhancement, and also to gain access to expertise outside of their immediate field, such as social and cultural insiders. Buse and Walt document a “multi-pronged strategy” on behalf of business to gain access to and influence health policy making on the global level during the 1990s (Buse and Walt 2002: 49). But seeking participation partnerships has also come as a result of interactions with other stakeholders, including increased pressure, articulated through advocacy groups, to engage in corporate social responsibility. The desire to gain a better reputation through social engagement therefore also provided a motivating factor. At the same time, public actors and advocacy groups might see public-private partnerships as a mechanism through which pressure can be placed on business actors to conform to certain standards and keep a check on their activities. By promoting a sense of ownership amongst all participants, PPPs have emerged as a mode through which the drive to achieve health aims can be met by strengthening the obligation to put other interests aside (See Huckel *et al.* 2007).

The motivations of large donor states and transnational corporations that advocate disease-specific “vertical” approaches appear most obvious in the context of PPPs, which are inherently narrow specific in focus. Reasons for acceptance or engagement on behalf of recipient states and NGOs are more ambivalent. While for some the decision to enter into partnerships can be traced to rational calculations of the benefits of pooling of resources, others might be traced back to logics of appropriateness, lack of alternatives or simply ‘going with the times’. The leadership role played by large states and prominent private donors have not only spurred the formation of large scale global PPPs but contributed to a pool of ‘gold standards’ for the ways in which developing states could and should engage with non-state actors. These standards have been replicated on regional as well as local levels.

#### **4. Unique features of health as an issue-area open to innovative governance.**

There are several peculiarities about health as an issue-area that promote cooperative forms of governance. This might not necessarily be in the form of PPPs, but, also inter-agency and intergovernmental cooperation or public sector programmes with private sector participation (WHO 2007). In this section I will briefly introduce five unique features of health as an issue-area that serve to influence actor motivations to engage in PPPs and created background conditions that have led to the promotion of PPPs as a particularly viable strategy for achieving health aims.

##### **4.1 Goal-oriented governance**

Health is an issue-area with a strong bio-medical background and the awareness of health challenges is often promoted through the dissemination of statistics and images of health emergencies, the spread of pandemics and acute health crises. Solutions therefore also tend to be presented as the achievement of disease eradication or increases in vital health indicators along the lines of ‘health is the absence of disease.’ This is coupled with a strong reliance on technological solutions and “(t)he view that science and technology could solve the world’s problems” (Bonita *et. al* 2007: 267). Throughout history health has therefore been an issue-area that tended towards a narrow goal orientation seeking clear, measurable results; and PPPs embody these principles.

Several events demonstrate how narrow goal orientation has shaped global health governance. The International Sanitary Conferences of the late 1800s were convened following specific concerns over how to control the spread of cholera and the World Health Organisation is said to have experienced its peak of success with the elimination of smallpox in the 1970s. Following the promotion of comprehensive primary health care in the late 1970s, the concept was soon ‘narrowed down’ to selective primary health care in the 1980s, for example, with the UNICEF ‘Child Survival’ strategy GOBI, which stood for growth monitoring, oral re-hydration therapy, breastfeeding and immunisation. Broad approaches that sought to embed health into models of community empowerment and the improvement of other social and economic determinant were criticised as too costly and complex (Magnussen *et. al* 2004: 170). Selective strategies that target specific high risk groups can be seen as less ambitious but more cost effective with the ability to “reduce mortality from common ailments until more comprehensive services could be put in place” (Hong 2004: 29, Walsch/Warren 1979: 972). Goal oriented governance in health has provided a fertile ground for the formation of public-private partnerships that by nature are specific in focus. This is for two main reasons:

First: Clear goal-orientation lends itself to approaches that emphasis cost-effectiveness and efficiency. For example Ridley *et al.* document that at least one global PPP, the Medicines for Malaria Venture was deliberately “run as a not-for-profit business... based on operational paradigms of industry, not the public sector” (Ridley *et. al* 1999). Public-private partnerships have been seen as lean mechanisms to achieve health aims by focusing on management principles from the private sector. “With an outcome orientation and efficient ‘lean’ governance structure, PPIs are expected to move fast in making medicines available to people living with HIV/AIDS (HAI 2007). As the title of the influential 1993 World Bank Report “Investing in Health” suggests, donors seek mechanisms through which goals can be achieved with limited resources at hand and where results reflect a good ‘return’ in relation to level of inputs.<sup>4</sup>

Second: The promise of observable and measurable results through statistics on mortality and morbidity and the publication of ‘intermediate indicators of success’ making results-oriented action attractive for stakeholders that seek to advance their reputation through partnering or demonstrate to constituencies the efficacy of aid programmes. It is therefore not surprising that PPPs concentrate heavily on measuring and displaying their levels of performance. With

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<sup>4</sup> For example the Bill and Melinda Gates foundation has repeatedly named immunization as a cost-effective investment in health. “Melinda and I believe that supporting GAVI is the best investment we’ve ever made. In just five years, GAVI has immunized tens of millions of children in the developing world, and saved hundreds of thousands of lives—that’s extraordinary progress” (Bill and Melinda Gates Foundation 2005)

a narrower scope of goals, gathering data on effectiveness is simplified in terms of immediate outputs, as well as intermediate outcomes and final impacts (see Huckel *et al.* 2007).

#### **4.2 The epidemiological transition**

One of the most devastating features of the global health landscape over the past 30 years has been visibly widening health gaps between the privileged (mostly in the North) and less advantage groups, (mostly in developing countries) (Bonita *et al.* 2007: 268). This has been exacerbated by the so-called "epidemiological transition" experienced by developed countries in the second half of the twentieth century "where infectious diseases stopped being the most important causes of death, and cardiovascular diseases and cancer became the main concerns" (Foladori 2003: 84). Accompanying this process, biomedical research within developed countries has come to concentrate on cancer, circulatory diseases, skin problems, and other diseases associated with high living standards (Foladori 2003: 85). By 2001, the US National Institutes of Health for example, reported that in the United States, 10% of R&D expenditure focused on cancer, 1.1 % on vaccines, and 5% for AIDS, including only 0.6% for AIDS vaccines (Kettler/Towse, 2001).

This transition has been key in the formation of the health gaps that have: first, influenced global political priorities by masking the threats that the burden of disease poses for the successful functioning of state and second, led to the need to artificially encourage research and development into non-profitable medicines by entering into agreements (and partnerships) with the private-sector. The development of policies to address tuberculosis (TB) is a lucid case study in the effects of the epidemiological transition. The discovery and comprehensive application of antibiotics and chemotherapy treatments in higher income countries led to the perception that the disease was "under control and perhaps even on the brink of eradication. (...) By the 1970s...there was declining political and, as a consequence declining financial, support for TB programmes...Internationally, financing of research waned and the number of TB-related staff at WHO headquarters dwindled to a single person" (Porter *et. al*: 187). Tuberculosis rates again increased throughout the 1980s and the disease was declared a "global emergency" by the WHO again in 1993, but, by this time, the capacity of many states to deal with the epidemic had already waned and the inability of affected persons in developing countries to pay for treatment meant that producing medicines for tuberculosis was a charitable rather than profitable project.

Many public-private partnerships for health are aimed at the development, supply and distribution of medical services for non-profitable diseases. The epidemiological transition has been one sided leading to often radically different national priorities in wealthy compared with developing countries. The inability of state-based governance or market driven development alone to achieve universal improving health and living standards can be seen as a driving force behind the proliferation of PPPs.

### 4.3 The role of the World Health Organisation

The World Health Organisation represents a special institution even amongst the group of specialised agencies incorporated into the UN System. Founded by the bringing together of several already strongly established regional organisations and given a strong mandate based on technical expertise, it has been situated at the centre of global health policy since its inception. "Since its foundation WHO has been the world leader in formulating professional consensus, setting international technical norms and defining health care standards" (Peabody 1995: 736). It is therefore not surprising that changes in governance, organisation and leadership at the WHO have a profound effect on the general direction of global health policy.

In the 1970s following the successful eradication of smallpox through "vertical" campaigns, the World Health Organisation, went through a major transition following a significant increase in membership of developing countries in the World Health Assembly, (as was the case of United Nations in general). The balance of power shifted away from previously dominant members and an increased concern with social determinants of health lead to a change in strategy direction towards strengthening health systems and in-country projects. During several years from the 1970s onwards, the WHO has faced a frozen budget in real terms and increasingly, wealthy donors have moved towards supporting extra-budgetary goal-oriented programmes. From the 1980s onwards the WHO began developing 'special' or disease specific intervention programmes which were intended to "boost the organisation's routine activities, using international and regional expertise and a project based approach to attack specific diseases or health issues (Godlee 1995: 179). These special programmes and they way they were funded and organised are an important precursor to public-private partnerships.

By 1996 it was found that " ... such extrabudgetary funds now account for over a half of the total expenditure of the (World Health) Organisation and more than 80% of these funds come from a small group of 10 industrialised donor countries" (Vaughan et. al 1996: 253)

"From the donors' point of view the special programmes have clear advantages over WHO's non-project based activities... By 1995, extrabudgetary payments to special programmes totalled over half of the WHO's income... All countries have equal voting rights at the World Health Assembly, so groupings of countries from the developing world can now control the assembly's agenda. By shifting their funds to the special programmes, donors can influence how their money is spent." (Godlee 1995: 179-180)

The World Health Organisation is so large in terms of number of activities and affiliated projects and staff that regular criticisms and calls for reform are probably unavoidable, as coordination between departments and regions is difficult. Each election of a new leader is usually accompanied by calls for new directions and new hopes for more effective and just approach to global health and different political eras have changed the overall approach of the WHO with clear goal oriented programmes sometimes encompassed within the organisation, sometimes located on the periphery and sometimes (semi) detached through public-private partnerships.

#### **4.4 Strong epistemic communities**

Today, many PPPs have decision making structures that rely not only on the input from representatives of the relevant ‘partners’ or stakeholders, but include executive or advisory boards occupied by “experts” that act in an individual capacity and are active in several sectors. In this sense PPPs can be seen as a mode through which the expertise of long active and influential epistemic communities in health have been “advanced” to a more central policy-influencing and decision-making role. Within public health, such epistemic communities are particularly active and influential, due to the highly scientific nature of the issue-area and the reliance on a background understanding of modes of disease transmission, aetiology and epidemiology. Experts with strong medical, public health and health economy backgrounds can therefore present themselves as being ‘an authority’ in global health, and technological approaches have thus dominated international and global health research and policy making.

Several authors hint at forms of elitism and exclusivity being created through the formation of closely networked epistemic communities in global health. For example, Lee and Goodman (2002) trace health care financing reform during the 1980s and 1990s to a close knit epistemic community of certain individuals, from both the state and non-state sectors; and Buse *et al.* (2002) extend this observation to health policy making on the global level more broadly to the point of the emergence of an ‘elite pluralism’ cutting across the state, private sector and civil society sectors. “In a sense, a ‘top’ slice of the most powerful actors in each sphere has become increasingly influential in decision-making” (Buse *et al.* 2002: 264).

Epistemic communities can be seen as providing the basis for the initial contacts and cross-sector trust relationships required for the establishment of public-private forms of cooperation. They can also be seen as a particularly powerful group of actors that promote bio-medical approaches to global health and belief in technical solutions that are manifested in goal-oriented public-private partnerships.

#### **4.5 The influence of acute and chronic pandemics: HIV/AIDS and SARS**

Health crises occur at often unpredictable times, and when they occur on a large enough scale they pose a highly visible and direct acute threat to individuals, and economic and political systems. Specific health crises have therefore provided an impetus to change political strategies and have influenced the motivations of states and other actors for entering into organised cooperative networks.

In describing the proliferation of inclusive and cooperative institutional arrangements on the global level, the rise of so called “transnational problems” has been cited as providing necessary contextual changes spurring the demand for innovative governance (Rittberger *et al.* 2007). Two pandemics that in relatively recent history have had a significant impact on global health governance, HIV/AIDS and SARS, embody these challenges and demonstrate how they play out with unique effects within the health issue-area.

David Fidler has suggested that the SARS outbreak in 2002/2003 triggered significant changes in global health governance trends and represents a “coming-of-age” in global health governance. SARS highlighted the vulnerability of communities all around the world to newly

emerging infectious diseases in an age of rapid movements of goods and people. Once and for all national borders seemed to offer no barrier in the age of globalisation where many pathogens have incubation periods longer than it takes to travel the globe (Saker *et al.* 28). This triggered a final shift away from traditional approaches to international health that put domestic policy control at the discretion of states (Fidler 2004: 799). Instead, adding to the onus on states to ensure adequate health of its citizens on the basis of concepts of health as a human right, keeping infectious diseases under control now became the responsibility of states as good global citizens. As SARS highlighted the inadequacy of some domestic public health systems, the involvement of non-state actors in roles of epidemiological tracking the provision of global public goods for health was encouraged. Although most countries reported SARS cases to the WHO (despite no formal obligation to do so) the WHO was able to benefit from non-governmental sources of information in countries that were initially not cooperative. The network of expert communities and partners in the field made a global campaign to control SARS possible, despite the epidemic arising suddenly with no previous knowledge on the causative agent available. The value of public-private cooperation in bringing together widely dispersed formal and informal networks became evident as this web ensured the provision of certain public goods during the crisis. According to Fidler the production of these goods “occurred through the participation of states, intergovernmental organizations, and non-state actors, and thus represents further evidence for the need for hybrid germ governance strategies” (Fidler 2004: 801)

The HIV/AIDS epidemic has had even more visible and long standing influence on political strategies towards global health. It is a unique epidemic which has been described as a long-wave event, because its effects compound over generations slowly undermining social structures and economies (Barnett 2004: 931). Because of its unique causes and effects “...(the) need to create a global response has never been stronger than in the case of the HIV/AIDS epidemic” (Hein *et. al* 2007: 227)

Garrett (2007) has pointed to the unique role that the AIDS pandemic has played in the considerable increase of financial resources flowing from development agencies into health projects in recent years. She argues that the dramatic difference in the way the HIV/AIDS epidemic was controlled in developed compared with developing countries highlighted the gap between wealthy and poor in a more visible way than ever before. With increasing public awareness, “between 1997 and 2000, a worldwide activist movement slowly developed to address this problem by putting pressure on drug companies to lower their prices or allow the generic manufacture of the new medicines” (Garrett 2007). A new era of global health during which vocal advocacy groups demanded action from states and for-profit actors alike to address a massive long-term threat pushed for innovative solutions to achieve results. Kickbusch (2007) adds a further elements to this view. HIV/AIDS not only emphasised the gap between the vulnerabilities of the wealthy and the poor spurring on the development of a global civil society network, it also highlighted the consequences of a lack of political will to take action (Kickbusch 2007: xi). She goes on to state that “The field of HIV/AIDS which was the revolutionary starting point of global health development has now become part of the problem. The large number of projects, programmes and partnerships that address single diseases, treatments or health crises such as HIV/AIDS may have actually reduced investment in other areas of public health and caused unintended consequences” (Kickbusch 2007: xv).

## **5. Concluding remarks**

With their massive presence, it is not surprising that public-private partnerships have been the focus of much attention amongst observers of public health and global governance alike. They have been both welcomed for the opportunities they bring, as well as criticised for the power they 'lend' to private actors (See Richter 2004; Zammit 2003; Sridhar 2003; Carson 2004; Bartsch 2002). It is important to critically question the extent to which public-private partnerships really represent something new in global health, or whether they have arisen as a way to reinforce old structures of control over global affairs on behalf of wealthy states and certain interest groups. On the one hand, certain key political events and the spread of certain diseases has had a profound impact on the motivations of actors to accept existing power constellations for the purpose of goal achievement. On the other hand, public-private partnering has formed out of pressure placed on those who preside over valuable resources to contribute more to alleviate poor health in the most vulnerable communities.

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