2.1.3. Global Public-Private Partnerships

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Introduction

We amply dealt with the history and evolution of partnerships, which culminated in the setting up of Global Public Private Partnerships (GPPPs) focusing on health programmes, in the first report of the *Osservatorio Italiano sulla Salute Globale*[1] (Italan Global Health Watch) in 2004.

Some authors have argued that the GPPP phenomenon is linked to structural changes, and destined to consolidate itself as such[2]. As we will see, the most recent trend in GPPPs shows shared awareness of the need to readjust the approach so as to reduce any negative impact on national health systems.

Definition

Health GPPPs, Global Health Partnerships (GHPs) could be defined as a collaboration relation which is:

- voluntary, each of the parties has its own interest in taking part;
- equal, each of the parties is autonomous;
- participative, allows for inter-governmental mechanisms;
- global, transcends national/regional boundaries as regards participants, objectives and operations;
- public-private, brings together at least three subjects, amongst which will be a firm (and/or industrial association) and an intergovernmental organisation;
- has health oriented objectives[3,4].

A recent study has shown that of the 90 or so GPPPs that exist, at least on paper[5], only 62 are effectively functioning and meet the established criteria[6]. Some authors, however, have reduced the number to 23[7], by rigorously selecting only those GPPPs where public and private are both, really and effectively, represented. Furthermore, GPPPs pursue a wide variety of different objectives, undertake different activities, and time periods for interventions and size differ too. Thus there is no common structure, no standard model of organisation, discernible among them and in order to analyse the validity of this approach, we must first decide on a working definition of a GPPP.

GPPPs can be classified on the basis of the main aims of the partnership:

1. research and development of a product (drugs, vaccines, technologies, etc.);
2. promotion, advocacy and public information;

3. regulations and quality certification;
4. coordination, technical support and assistance for access to specific goods and services;
5. funding specific programmes[8].

Any evaluation of the validity of the model must first differentiate between the diverse typologies. Furthermore, GPPPs are of very different sizes and have very different degrees of political influence so they cannot be examined using the same criteria for all. On the other hand, no category is absolute, a GPPP often operates in more than one category and now, increasingly, they are interacting directly with each other. As we said in the 2004 Report, overall, GPPPs pose two main types of problems: a) their influence on governance and the global agenda; b) their impact on national health systems and consequently, in the final analysis, on their ability to contribute effectively to improving the state of health of the population, in a sustainable and lasting manner[9], In this article we will try to summarise the state of the art today, on the basis of the recently published literature, a decade after GPPPs first came into being.

Pros and cons

At the global level, GPPPs have certainly achieved a lot. They have increased the visibility of certain diseases (above all, contagious diseases); put some health issues firmly on the political agenda; contributed to generating additional resources for specific actions or for the development of new products; and, worked to improve norms, standards and treatment plans for individual diseases. At the national level, the GPPPs' merits lie in having made quality drugs and vaccines accessible to communities who did not have them before and, in some cases, of having contributed to improving regulations and management procedures in the specific areas where they are active[10].

On the other hand, the proliferation and the spectacular performances of some GPPPs is not without its risks, risks which cannot be ignored, and even observers who normally pay little attention to health issues have warned of this. In 2007, the issue of GPPPs was the cover story of the prestigious US magazine *Foreign Affairs*: "Today, thanks to a recent extraordinary and unprecedented rise in public and private giving, more money is being directed toward pressing health challenges than ever before. But because the efforts this money is paying for are largely uncoordinated and directed mostly at specific high-profile diseases – rather than at public health in general – there is a grave danger that the current age of generosity could not only fall short of expectations but actually make things worse on the ground"[11]. The fragmentation produced by the growing number of vertical initiatives underway in aid for development, and doubts about their sustainability when the initiative is not aligned with each Country's own programmes, is a problem that has been posed by many such as: the International Development Agency of the World Bank[12]; the International Monetary Fund IMF[13] and, in a study developed by McKinsey, one of the best known multinational management consultancy firms[14].

At the global level people are also talking about the question of legitimacy and the accountability of GPPPs, revealing that even there where an individual GPPP can claim legitimacy and accountability within their specific area of intervention, the sum of all GPPP activities "does not necessarily lead to a coherent health policy but can contribute to a fragmentation both at global and national level"[15]. Also, GPPPs compete among themselves and with others to attract resources, which are limited, therefore "the proliferation of GPPPs might lead to distortion of funding and further verticalisation of health policies"[16]. Lastly, GPPPs can be used by "big players" to circumvent consolidated organisations, such as the World Health Organisation (WHO), thus weakening the latter organisation's influence as an actor within global health[17]. As well as influencing the mission and the priorities of global public health policies, the absence of a clear framework of norms and principles within which partnership agreements could be developed, and the trivialization of the conflict of interests arising from the participation of for-profit private partners, both pose a further challenge to ethics. At least in the long term, for-profit partners will demand some economic return[18].

Buse and Harmer analysed 23 GPPPs and identified 7 defects amongst which were, at the global level: poor governance (also in terms of defining and sharing roles between partners, monitoring and transparency); vilification of the public sector (with particular reference to the World health Organisation (WHO); representation deficits (which, furthermore, are skewed in favour of the private sector despite their modest financial contribution); less, i.e. inadequate, financial resources contributed by partners with respect to the financial commitments collectively approved and accepted[19].

In individual countries, some studies have suggested, that the main worries are about the bigger health GPPPs (for example the Global Fund for the battle against HIV/AIDS, tuberculosis and malaria, GFATM; the Global Alliance for Vaccines, GAVI; Stop TB and *Roll Back Malaria*, RBM). There are significant differences in the *modus operandi of* each of these: the first two function mainly as agencies for providing funds, while Stop TB and RBM aim to coordinate interventions in their respective areas of interest, to promote and offer technical assistance[20]. Generally, the negative impact is linked to incompatibilities, often noted by development workers, between vertical interventions and horizontally organised health systems with limited resources. One study, carried out in 20 countries, identified three orders of determining factors[21].

The first order is the introduction of inappropriate and unsustainable technologies and strategies, which overload national systems and institutions that are already weakened and impoverished. For example, the push to introduce new vaccines (like the vaccine against Hepatitis B promoted by GAVI) or specific antiretrovirals or anti malarial drugs (as in the case of PEPFAR* for the former and GFATM for the latter) is not based on contextualised cost-benefit evaluations, nor does it take into account inherent aspects of logistics and sustainability within each

* PEPFAR: The President's Emergency Plan for AIDS Relief launched by President Bush in 2003.

specific context, i.e. each local health system. For example, introducing antiretroviral drugs without also increasing the number of health workers does nothing, except undermine the local health system[22]. But GPPPs do not take structural weakness (or absence) into consideration rather, at times, they risk making things worse. As in the case of GFATM, whose competitive recruiting of (often scarce) personnel for its projects, effectively takes them away from other sectors of the local health system[23].

The second order concerns the multiplication of the parallel and additional processes imposed by each new GPPP: with consequent wastage of resources. In order to benefit from the funds of each GPPP, countries must invest heavily in specific planning exercises, write applications for financing and reports, and must use forms, times, processes, procedures and channels for funds, as well as supply systems, that are different every time, and, moreover, use their own scarce resources too, or those supplied by another of the partners, since GPPPs usually do not provide human and material resources for setting up and monitoring projects. Many of these have set up specific national coordination mechanisms to guide and manage GPPPs, (such as the CCM** of GFATM, or the ICC*** of GAVI) but their functions often overlap. Funding from each GPPP usually comes through separate channels, which are often not the normal institutional channels. Because they tend to assume that public health services do not function anyway and, because they want rapid results, GPPPs have often chosen to work outside of national health systems, and in the end they often only "suck resources out of them"[24].

The third concerns the inability of global initiatives to adapt to local situations, a lack of flexibility which frequently forces countries to adapt their needs to those of the GPPP. Even communication with local partners is often inefficacious and the GPPP may find it difficult to understand local needs, limits and dynamics. Lastly, even at the local level, the roles of the different international partners are rarely well-defined.

The future

When the idea of a new Global Fund first began to be discussed, G8 health experts convened by the Italian presidency, revealed very different orientations except on one point where they all seemed to agree: that it was not an opportune moment to propose setting up a new organisation given that, until just a few weeks previously, the subject had not even been part of the (explicit) G8 agenda[25]. Political leaders forced a change in the agenda and the Global Fund was added to the, already numerous, existing GPPPs. Six years later, faced with more and more evaluations illustrating the negative consequences of this approach, Gordon Brown (UK Prime Minister) convened diverse members of G8 and many bilateral and

** Country Coordinating Mechanisms.
***Interagency Coordinating Committee.

multilateral partners, including representatives from some GPPPs, for discussions. They agreed to commit themselves to reorienting the focus of their initiatives so that they would now begin to support the health systems of the beneficiary countries, by harmonising and coordinating activities, in accordance with the proposals laid down in the Paris Declaration on Aid effectiveness[26], through a newly set up International Partnership for Health[27]. A good intention and a needed move, but in our opinion, the most appropriate place for such a commitment would have been the World Health Assembly, so reinforcing the role and broadening the global health governance capacity of the World Health Organisation along the principles that originally inspired it

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