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Editorial: Partnership and fragmentation in international health: threat or opportunity?

Gill Walt, Kent Buse

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The landscape of international collaboration in health is changing. Where once international health was dominated by the public sector through the UN's specialized agency for health, WHO, today there is much greater diversity. Not only are the World Bank and European Union increasingly playing an active role, but so too are a number of important new philanthropic foundations[1] and the private-for-profit sector, such as the pharmaceutical industry. Furthermore, these diverse players are forming a bewildering array of new partnerships, networks and alliances, which even include both private and public actors to address particular international health problems (Buse & Walt 2000a,b). The Global Alliance for Vaccines and Immunization (GAVI) provides one example of a newly formed coalition of public and private institutions, including several UN bodies, the pharmaceutical industry, government aid agencies and nongovernmental organizations (NGOs). Established in 1999, GAVI has received US$ 750 million for 5 years from the Bill & Melinda Gates Foundation, and is promised more if US President Clinton's proposals to Congress for additional resources are passed. Four US pharmaceutical companies have agreed to donate $150 million worth of vaccines through GAVI (Smith 2000).

Why have these global public-private partnerships been established?

There are many reasons why WHO is no longer the main player on the international health stage. The Organization was criticized during the 1990s, for, among other things, its lack of effective response to health challenges. One of the earliest public–private partnerships was the Task Force on Child Survival and Development, formed in 1986 to overcome institutional rivalries within the UN (Muraskin 1998), but also to spearhead the childhood immunization campaign. Its successes – among them working with others to achieve the near-elimination of polio worldwide – have encouraged donors to form other partnerships. During the 1980s and 1990s the prevailing ideology, which favoured market forces and privatization, led to increased channelling of public funds towards NGOs and greater opportunities for involvement of the private-for-profit sector in health. At the same time, shrinking financial resources for the public sector, and concern over the withdrawal of industry from the manufacture and development of vaccines, diagnostics and medicines for tropical diseases, initiated a discourse focusing on new modes of collaboration between the public and private sectors. While collaboration between the two sectors was seen as a *sine qua non*, their mandates were perceived as quite divergent, and much of the discussion revolved around bridging those differences (Harrison & Lederberg 1997). This discourse began to change, and by the end of the 1990s a remarkable number of public–private partnerships had been crafted. For the private sector, these initiatives were increasingly viewed less from the perspective of traditional philanthropy, and more as a way of using core business competencies within partnerships with the public sector so as to secure strategic corporate gain (Waddell 1999), which included a demonstration of increased social responsibility. For the public sector, such initiatives promised an injection of much needed resources to neglected health issues. Through this process, innovative public–private arrangements have been established which harness market forces and provide commercial incentives to solve seemingly intractable health problems that result from a combination of market and public failure. Thus, for example, large purchase funds, 'roaming exclusivity clauses' and other forms of intellectual property rights sharing have been established to provide incentives to the pharmaceutical industry for the development of global public goods such as new drugs and vaccines (Ashraf 2000).

Where is funding coming from, and what effects may this have on international health?

While the injection of funds and innovative partnerships to solve some current international health problems is greatly welcomed, three caveats are in order.

First, the new diversity of actors in international health is reflected in changes in the configuration of international aid. Flows of public funds have declined in comparison with private flows. Multilateral funds have increased relative to bilateral funds, and are increasingly likely to be selective in favour of countries judged to have 'good policy environments' (World Bank 1998). Yet the poorest countries are the least likely to have the characteristics of 'good' policy environments[2], and need support to establish them. While it is not surprising that private investment flows towards countries that guarantee returns, the disbursement of public funds through international aid cannot be made on the same basis without increasing inequalities and putting the poor at even greater disadvantage. The advent of public–private partnerships may result in additional public resources being subject to 'aid selectivity' as they follow private sector interests and priorities.

Second, the growth of private funds is particularly marked in international health. The new philanthropists – particularly the Bill and Melinda Gates Foundation – are making a significant financial contribution to global health. The Gates Foundation grew by almost US$ 20 billion in one year to become the largest foundation in the world in January 2000, with assets exceeding US$ 21 billion. In 1999 the Gates Foundation announced a US$ 6 billion investment in developing new vaccines and getting vaccines to populations which currently do not receive them, making it the largest charitable donor of the 20th century (UN Wire 23 August 1999). It is unclear how much of this commitment to vaccines has been disbursed: the Foundation provides limited data on its website[3]. The table below provides some information on a selected number of grants made, not including the US$ 100 million for the Children's Vaccine Programme nor the US$ 1.5 million for the International AIDS Vaccine Initiative in 1998. Large funders wield significant influence, and the new philanthropic foundations, which rely on the experience and expertise of relatively limited numbers of advisors, and have largely inward accountability, today have far greater financial influence (hence power) than many government aid agencies. On the US$ 50 million grant to establish a Malaria Vaccine Initiative in 1999, Gates is quoted as remarking 'With one grant we became the biggest private funder of malaria research' (quoted in Strouse 2000).

Finally, through partnerships, private-for-profit firms have made significant contributions to health worldwide: Merck, for example, through its Mectizan Donation Programme, has donated drugs worth a purported US$ 500 million over about a 10-year period for onchocerchasis control, plus providing an additional US$ 200 000 *per annum* for shipping and administration of the Programme (B. Colatrella, personal communication). The Zithromax Donation Programme by Pfizer is valued at US$ 60 million, and the company together with the Edna McConnell Clark Foundation is providing another US 3.2 million to the International Trachoma Initiative over a 2-year period[4]. These figures stand in stark contrast to WHO's annual regular budget which has stagnated over the past decade at about US$ 800 million per year, and whose funding for immunization (other than polio) was only around US$ 18 million in 1997 (Brooks *et al.* 1999). Yet, because of concerns about public perceptions, private-for-profit partnerships are inclined to be highly selective in their choice of activities and thereby, for example, less likely to tackle stigmatizing issues such as the control of sexually transmitted diseases or problematic issues such as support for failing health systems. Thus, while such large injections of funds into international health are badly needed, there are major issues which have to be considered:

Most of the focus of the 'new' resources is on infectious diseases. While there are good reasons for this emphasis – much of the technology is already available but not being widely used (e.g. vaccines against hepatitis B), effort is needed to support research (e.g. for improved TB or malaria drugs, or for an AIDS vaccine), and infectious diseases remain a major threat to health – there is a danger that this focus diverts attention from other causes of ill health and is over-reliant on technological solutions.

Partnerships which focus on product development or donation may underestimate the difficulties of delivering vaccines and supporting weak health systems. For example, the costs of vaccines are only a fraction of the cost of a vaccination programme. Mahoney and Maynard (1999) estimate that the cost of the vaccine per fully immunized child is only US$ 1.50, against the total cost of $15. The balance is incurred in staff salaries, transport, facilities and training. Partnership initiatives are often reluctant to support such recurrent expenditure for health systems, yet in the poorest countries it is basic health infrastructures that are most fragile. While many new partnership programmes aim to strengthen weak systems[5] and should be encouraged to expand this area of their operations, it is difficult and time-consuming to address the problems pertaining to routine services, especially where they have been severely eroded. As Cutts (2000) has pointed out, institutional memory in immunization programmes has been lost as the new generation of managers focus on polio eradication. Others have expressed concern about the diversion of resources from routine health services to support donation programmes (Kale 1999).

Public–private partnerships also raise fundamental questions of governance, both in relation to the institutional arrangements within the partnerships themselves, as well as in relation to the broader arenas of international and global health co-operation. With a few exceptions, institutional governance appears underdeveloped. The Gates Foundation is largely a family affair, with no official board to oversee and monitor activities, albeit with considerable consultation among different domestic constituencies. Many partnerships have little representation from recipient countries either on governing boards, or on technical, advisory, or grant-giving committees. There is a lack of information in the public domain about the composition of different committees of boards of management, or about mechanisms of accountability within partnerships or coalitions. While websites, increasingly the mode of communication between partnerships and the external world, often give basic information and are easily accessible, they do not always give information on the volume, allocation and monitoring of resources, nor on how decisions are made and who can be held responsible for them. Huge amounts of resources are being allocated by relatively small policy communities, with many overlaps in membership and management between the different committees and partnerships. Further, organizations such as the Gates Foundation, required by US tax laws to give 5% of their endowment to charity each year (now more than US$ 1 billion per year – WHO's total budget for the whole world) are under enormous pressure to disburse money rapidly. Porter and Kramer (1999) argue that to justify tax exempt status, foundations need to improve their performance and accountability to the public.

Governance at the global and international levels is also of concern. With priorities decided by small communities of experts often removed from the realities of programme execution, the question arises who is setting the policy agenda in international health. Global public–private partnerships are, by definition, focused on specific public health problems, and most select some, not all, countries affected in which to work. WHO's role as a normative agency, advising countries about standards and norms, undertaking global surveillance, providing support for cross-learning, advocating, producing and distributing international public goods, may well be undermined by these partnerships. While WHO's role is by no means uncontested, there is still much support for many of its normative functions – especially in low and middle-income countries – and it is not clear how far the new global public–private partnerships affect WHO's traditional functions. The Organization is usually included in such partnerships, and therefore has a voice, although one among many. Its own characteristics of universality (membership of 191 countries) and representation (member states decide policy at the World Health Assembly) are not reflected in public–private partnerships which often have little low or middle-income country representation, and lines of accountability upward towards their sponsors rather than downward towards recipients.

Finally, there are concerns that partnerships may exacerbate inequalities or disadvantage the poor, both globally and within countries. For understandable reasons, partnerships focus their activities – at least initially – on countries which offer a reasonable chance of successful outcome. They are also likely to be those countries with historical geographical ties to partners, countries with incipient markets, countries that are relatively stable, countries that 'sign on' (GAVI requires countries with a GNP of less than US$ 1000 per person to 'express an interest' in applying to receive vaccines – early this year, 47 of 74 eligible countries had responded positively to GAVI). Such selectivity may well favour better-off countries relative to the very poor. The question then is where global responsibility lies – is it with a WHO relatively undermined by the changed landscape? Within countries, a few voices have raised concerns about the unintended consequences for the poor of drug donation programmes: diverting resources from already weak health systems; exacerbating inequalities between private and public sectors where leakage commonly occurs; and creating problems of sustainability for resource-challenged health services (Shretta *et al.* 2000).

The international health landscape appears increasingly fragmented, with diverse players in overlapping coalitions, alliances and partnerships working together towards very specific, often disease-orientated goals. Because they are very new – the Mectizan Donation Programme established in 1987 being one of the earliest examples – little is known about how they work, or their systems of governance[6] and what their unintended consequences might entail. The newcomers, such as the Gates Foundation and the socially aware corporate sector, have raised the profile of international health, and helped to create a much higher profile for infectious diseases and vaccine development. For communities suffering from the impact of HIV, malaria, trachoma, onchocerchiasis, or filariasis – just some of the diseases targeted by global public–private partnerships – there are clear benefits. But there are also costs to this changed operating system. For example, a report in the *New York Times* noted that many scientists were unwilling to voice criticisms of the Gates Foundation on the record because their institutions hoped to receive Gates' grants (Strouse 2000). Bilateral agencies are having to find ways of establishing criteria for when and how to use public funds to support private industry efforts in the belief that there will be future gains for poor people. All partners have to look at the opportunity costs of managing partnerships in terms of participating in meetings and monitoring and evaluation of programmes. As the number of partnerships grow, so do such costs. Moreover, there are costs around targets and priorities, with the danger that too much attention to specific disease programmes, which can be relatively easily measured and assessed in terms of outcomes, may attract partnerships and resources but detract from support for the systems which deliver services. Finally, are there dangers that WHO's credibility, impartiality and integrity, appreciated especially in low and middle-income countries, but by no means guaranteed, could be undermined by a fragmenting system in which no single agency is the 'world's health conscience'?

As the world moves away from the vertical, state-centred structures that made WHO accountable to its members, calls are increasingly being made for a rethinking in international health governance to loose horizontal networks, where it is unclear who is really making decisions and who is accountable to whom. Global public–private partnerships are just one aspect of increased fragmentation in international health, which may be undermining specialized agencies such as WHO. However, while concern is being expressed, few solutions are obvious. Some would like to see WHO strengthened, with sustainable financial resources, while others would like to see another type of voluntary global forum that might regulate international health activities. The debate on which global structures will be in the best interests of the public's health is only just starting.

References

Footnotes

• 1 George Soros's Open Society Foundation and the Bill and Melinda Gates Foundation are just two examples of such philanthropists, who have targeted significant new resources for specific health problems.

• 2 A good policy environment is characterized by, for example, the rule of law, an open and regulated financial system, human rights protection.

• 3 This estimation was for vaccines alone, and does not cover other grants made for drug development such as 25% for malaria, or $50 m for Save the Children for infants. Retrieved from the Website: www.gatesfoundation.org

• 4 Contributions are tax deductible, so costs to such companies may be less than stated costs, and may be a small fraction of net profits.

• 5 The Malarone Donation Programme is stimulating improved laboratory diagnosis of malaria (Lucas 2000).

• 6 Exceptions are Frost *et al.* (2000) on Mectizan, and Barrett et al. (2000) on the International Trachoma Initiative.

Citing Literature

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