

**Public-private partnerships and global health coalitions  
as global means of social inclusion**

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## Abstract

This paper reviews the role of public-private partnerships in a global context with special reference to the health care sphere. The purpose of this work is to focus on different patterns of international alliances in order to assess whether they may help reducing major health inequalities thus acting as new global systems of social inclusion. The paper investigates, in particular, how global interactions between public institutions and the private sector may influence the decision-making process, thereby jeopardising the achievement of public goals such as the one of primary health safeguard. The study aims at exploring the landscape of global health alliances by providing a comparative analysis of different cases of partnerships such as GAVI and '3 by 5', outlining their main differences in terms of governance structures and selective and universalist approaches to social inclusion. Eventually, the work attempts to understand whether a correlation between policy patterns and outcomes of global partnerships may be found. It will be suggested that a classification focused on the role of the private sector within the governance structure may help assessing how global health policies are shaped by economic interests and what implications may be outlined for the achievements of local needs.

## Introduction

In recent years, considerable attention in social policy studies has been devoted to interpreting and assessing how national welfare systems are responding to the common need for major reforms (Esping-Andersen, 2002; Castles, 2004). Although this has led to heated debates and different answers are being suggested, most accounts agree that the crisis originated in political, social, economic and demographic transformations which have created a new social demand that traditional welfare state cannot satisfy (Ferrera and Rhodes, 2000; Giddens, 2000; Paci, 2005 ). As a result, during the last years, domestic systems have shifted from welfare states to welfare mix models since national governments have increasingly delegated social policy objectives to the private sector and to informal channels of social protection. The privatisation of social protection, which has been extensively discussed with regard to the engagement of non-state actors in domestic welfare systems, is now affecting supranational, regional and global frameworks of social policy. Such scenario, while demanding further consideration about the evolution of the welfare reform in

western systems, creates crucial challenges for developing countries which face, at the same time, international economic pressure and dramatic need for social inclusion.

This paper looks at the role of global actors in providing new means of social inclusion through Global Public-Private Partnerships initiatives. It first deals with the theoretical debates about globalisation, social policy and global inequalities. Then it reviews the trend of emerging GPPPs by attempting to examine two cases of global health initiatives.

In this view, GAVI presents a functional case study which – compared with the WHO pattern - may help understanding roles, limits and opportunities of different categories of public-private alliances. Two main topics will be discussed with regard to the GAVI partnership model in a context of emerging, alternative paths of social protection: the alleged shift of political power - away from public institutions towards the private sector – created by public-private governance, and the patterns outlined by universal and selective approaches to social policy. Afterwards, with regard to identified models of targeting and governance structures, the main question will be whether 'soft', universalism-oriented global partnerships or more selective logics of social protection proposed by the market agendas are more appropriate to face global inequalities.

### Conceptual Overview

The attention towards globalisation is central to several debates about the current evolution of national systems of social protection. There is a growing interest in exploring risks and potentialities that the recent wave of globalisation produces as a leading force of these transformations. As it has been noted, globalisation and social policy may be linked at least in three different ways which outline three different frameworks of study (Yeates, 2001). This connection is firstly being examined within the theoretical debate over the impact of economic globalisation on domestic systems of social protection. This discussion has also highlighted that economic competitiveness and race to the bottom threats have made most welfare systems objectives no longer financially sustainable (Taylor-Gooby, 1997). Furthermore, national social policies may be read looking at their capacity for contributing to economic competitiveness. These studies focuses on the role of social policy systems in shaping the current international economy.

Finally, Yeates and Deacon remind us that the issue of a global social policy is also being explored with regard to new supra-national levels of social redistribution and provision of social rights

(Deacon, 2000; Yeates, 2001). The globalisation of social policy, it is said, can be tracked in the commitment of international organisms which have assumed a concrete role in defining social protection in the global arena. Far from having established a comprehensive, universal agenda of global social protection, global institutions - such as the World Health Organization - have nonetheless created alternative global platforms for dealing with increasing inequalities. Further connections between globalisation and social policy emerge from the discourse on social exclusion. Poverty and deprivation have engendered profound debates which cannot be examined here in detail. This work moves from the concept of social exclusion as a relative and graduated notion which creates a status of multidimensional and cumulative deprivation concerning income, housing, education and health care (Atkinson, 2002). The paper also refers to social inclusion policies as part of a new approach to fight mechanisms which help producing and reproducing different levels of social inequality and deprivation (Sen, 2000). Thus, in a global perspective, we can follow Sen (2002) again by focusing on the relevance of non-market institutions – such as political, social and legal institutions – in reducing global inequalities created by market forces . This work will try to conjugate such framework of studies, by adopting an approach which links the theoretical debate on the global dimension of social policy with an analysis of institutional data presented by Global Public-Private Partnerships (GPPPs) and UN.

The theme of a global social policy, both as a normative and a descriptive notion is even more relevant since when non-governmental organisations and the market entered the international field of social protection. The recourse to strategic alliances of public institutions with the private sector is not new. The trend of emerging public-private partnerships in the realm of global social protection has long disclosed outstanding opportunities for the reduction of global inequalities and it is increasingly being explored with growing attention both in the institutional and in scientific literature. As it has been noted (Jütting, 1999), the interest in public private partnerships as means of social protection in developed and developing countries mainly comes from the potential of private actors for providing efficient social services and for establishing important mechanisms of cooperation with local institutions. Nonetheless, different patterns of interaction exist and confusion still emerges from the fact that a number of different labels are applied to the concept of public-private partnerships. As Richter states, moreover, the same expression is also being used for referring to several, different forms of interaction: collaboration with the business sector; public-private joint initiatives; multi stake-holders dialogues; venture philanthropy and so on (Richter, 2004). In this work, the definition outlined by Buse and Walt will be adopted. Following the

descriptions provided by the World Health Organization, these authors have proposed a specific definition of Global Public-Private Partnership for Health as 'a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour' (Buse and Walt, 2000). The extent of such interpretation lies in the acknowledgement that most GPPPs involve more than two parties, frequently including representatives from civil society and from the private sector, non governmental organisations (NGOs) and research institutes. Given such background, the theme of global alliances may be read as a crucial issue of contemporary social policy. It represents a core theme in current debates on a prospective system of global welfare and, at the same time, it may spot a *trait d'union* among parallel approaches and literatures on the fight against social exclusion. This paper is based on the theoretical assumption that the impact of global public-private partnership may be assessed by treating global alliances as systems of social protection. Therefore it follows the approach which adopts a broad definition of social policy, 'to include governmental and non-governmental public action to shape provisioning such as health and education, including influencing the distributive outcomes of social sector market processes' (Mackintosh and Tinbandeage, 2002). The main point of this work is that, besides representing a crucial issue in social policy studies, the topic of global health coalitions is a matter of great political relevance. If we accept the idea that social policy can be regarded as a system of social stratification rather than a mere mechanism of redistribution, (Esping-Andersen, 1990), then a prospective more effective governance of social policies in the health field becomes a potential outstanding chance of narrowing global social inequalities. While recognising this opportunity, this approach also reminds us that social policy models have historically promoted social dualism when they implemented means-tested social assistance. At the same time, outstanding accounts have reviewed the impact of national policy agenda on retrenchment initiatives in terms of links between political approach, eligibility rules and benefits reductions (Pierson, 2000). It is worth noting that such framework may also help understanding limits and functions of global social policy initiatives provided by international organisations, because they are developed and shaped by political commitment as well as national policies are.

Deacon (2000) has identified three (similar) models of global social policy adopted by different international institutions. As a result, we can have liberal, conservative and investment-oriented paradigms of global social policy. Similarly, we can note that different approaches to goals and

methods of social inclusion may define various patterns of global partnerships, ranging from universalist systems to more selective models. This work aims at demonstrating that, far from converging on a single, comprehensive model, current public-private partnerships can be rather classified according to approaches and patterns of governance. In this view, while the extent of global public-private partnerships has been long recognised, further effort is required to determine whether current global health partnerships can be regarded as universal means of social inclusion or as 'top-down' mechanisms of distribution which consolidate divisions between North and South of the world.

Most institutional reviews (WHO, the World Bank) are welcoming the recent massive involvement of public-private partnerships in global health initiatives, suggesting that the interactions with the business sector are rapidly establishing greater pluralism in international organisations, providing new means for fighting deprivation and social exclusion in developing countries. At the same time, several accounts express scepticism about a presumed shift of political power, away from public institutions – such as UN - towards the economic interests of private partners. Targets outlined by global health partnerships, it will be suggested, may diverge from domestic priorities, whereas developing countries require comprehensive approaches and tailored multidisciplinary efforts in different spheres of health policy.

### Public-private partnerships in the health field

The current stage of global interdependence has been extensively debated in respect of the weighty impact of market forces on domestic social policy (Ferrera, 1993; Rhodes, 1997; Castles, 2004). Though several crucial transformations have occurred in the safeguard systems of social standards, this work intends to focus on the global health dimension of this realm. Despite major domestic differences, the health care held for decades a key role in almost every national welfare programme. Nonetheless, as it has been noted, sociological approaches to social protection policies have rarely focused on empirical aspects of health policy (Padamsee, 2005).

This trend has been recently transformed by a renewed attention towards health issues both in western and in developing countries literatures. It is now become evident that traditional contents of national social policy, including health programmes, are being extended to global frameworks of governance. Consequently, general consensus is being addressed towards the fact

that the emergence of new supranational levels of the decision making process has also paved the way to new models of transnational coordination between national and local governments, economic actors and civil society. As above mentioned, part of the debate on the welfare reform has reviewed the introduction of market forces in the health care systems (Maynard et al., 2005). This framework of studies has been developed in different streams. Growing evidence is being addressed towards the fact that, striving to deal with global competition, domestic social expenditures of welfare systems are being subject to major adjustments, at least, according to Castles, in the structure of provision (2004). As a result, the realm of the health care is also being explored with regard to the engagement of non-state actors, both belonging to the business sector and to the non-profit sphere, which now compete with and frequently substitute the public supply of health protection (Paci, 2005). Different studies have then investigated the connections between the commercialisation of the health care and dynamics which generate social inequalities (Mackintosh, 2003).

With regard to the context of developing countries, theoretical debates and institutional reviews have demonstrated that the health care remains a core pillar of social and economic development which requires enormous commitment as 'Support-led Security' strategies can directly help raising the quality of life (Sen and Drèze, 1991; Sen, 2000). Recognising that developing countries are still facing major failures in meeting basic needs, delivering health services to the poorest and spreading health informations, international organisations have increasingly acknowledged that the social determinants of health are a main aspect of any initiative which aims at reducing poverty as a multidimensional phenomenon (WHO, 2004).

A major outcome of these acknowledgement is represented by the recent massive commitment of several global institutions to fight health inequalities in poor countries. The most evident feature of such initiatives is the wide and recurrent collaboration with the private sector. This trend is being explored both within the theoretical debate and in the agenda of international and non-governmental organizations, which are directly involved in such phenomenon as main actors of an embryonic form of global health policy. We can state that these interactions represent a major aspect of the contemporary international evolution of the social protection. Nonetheless, such mechanisms are still in progress and, therefore, a classification of models may benefit more from an overview of existing patterns, rather than being evaluated through abstract schemes of interpretation.

The extent of such engagement, as we shall see below, has recently been questioned and GPPPs are still regarded nothing more than 'social experiments' (Buse, 2004); notwithstanding, these

initiatives have gained remarkable importance in the current literature and the ‘global health related public-private partnership’ model is frequently being mentioned as a recurrent model of global governance.

### Discerning patterns of GPPPs

The trend of establishing strategic global health alliances originated from an increasing awareness of global institutions towards the fact that the response to the most weighty health issues advocates enormous dedication for finding resources and adequate expertise.

Although most initiatives which involve private enterprise are generally labelled as cases of public-private partnership, a closer inspection shows that different typologies of global health alliances can be discerned. Global health partnerships are characterised by different patterns of internal organisation, according to the typology of interactions between partners, as well as on the extent and on the content of the policies. Mechanisms of interaction may range from simple bilateral collaborations with donors to highly complex governance structures. The realm of GPPPs in the North and in the South of the world is extremely variegated and cannot be examined here in detail. Nonetheless, a brief description of two cases of global health alliances will be presented, in order to show that political approaches and governance structures may produce differences in terms of policy paradigms and impact.

### *GAVI*

The GAVI Alliance is considered one of the most significant cases of global public-private partnership for health and a model for prospective health alliances.

GAVI - formerly ‘Global Alliance for Vaccines and Immunization’-was launched in 1999 when the Bill and Melissa Gates Foundation donated 750 million dollars to the GAVI Fund<sup>1</sup>. The initiative was established with the intent of enhancing the diffusion of vaccines, hugely threatened by a continuous decline in the number of immunisations and by a weighty wide global disparity which has for long impeded the access to vaccines treatments in several poor regions of the world. The

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<sup>1</sup> Formerly known as the Vaccine Fund.



GAVI mission, therefore, primarily consists of guaranteeing equitable protection of every child in the world from preventable diseases by extending vaccine treatments. At the same time, GAVI aims at supporting research, development and the introduction of new vaccines and technologies. These ambitious targets are pursued following the inspiring principle of the alliance, according to which the GAVI purpose it to ‘harness the strength of multiple partners in immunization’ in order to increase successful cases in the tangled area of health protection. The board structure of GAVI reflects the above consideration presenting a broad spectrum of participants (fig.1). The GAVI Board includes a group of twelve rotating members (three national governments representing developing countries, three national governments from industrialised countries, one technical health institute, two representatives from the vaccine industry - one each for the developing and industrialised countries - and one NGO).

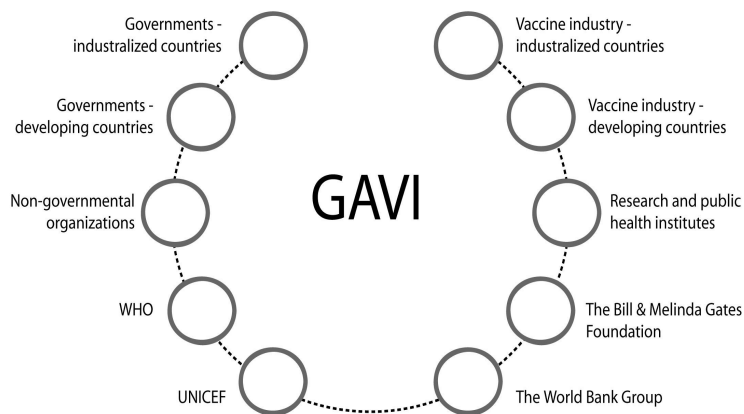


Fig.1: GAVI partners

Source: GAVI Alliance, 2006

The huge endeavour demanded by a project of global immunisation widely justifies such pluralistic participation, implying multi-sectoral approaches in different domains of research, intervention and monitoring. In this regard, the diseases control and prevention programmes, as well as general policies of health promotion, are assigned to the domain of national governments interventions. A

major priority of the coalition, therefore, implies fundamental efficiency of governments which are accountable for the implementation of the immunisation treatments. Furthermore, a close collaboration among states, the private sector and local communities is required, so that the impact of the GAVI activities can be efficaciously supported and maximised. Links with regional monitoring working groups have been introduced with the intention of eliminating bureaucratic barriers and the duplication of activities. WHO obviously plays a decisive role in defining the GAVI strategies by supplying technical experience - which derives from previous activities in the field of vaccine programmes - while the UNICEF has been designated to execute the realisation of prevention and immunisation activities. In spite of the preeminence of such institutions, the Alliance firmly stresses the importance of the GAVI 'added value', ascribing the potentialities of the coalition to the fact that it represents a 'unique forum for building consensus on policies'. The World Bank Group, for example, represents an important link between the Alliance and the states, increasing loans to countries involved in immunisation programmes and discussing mechanisms of financing vaccine projects with governments. A major connection with the scientific community has been established as well, with the involvement of research institutes represented on the alliance board. Finally, the presence of the pharmaceutical industry has been included for the purpose of allowing an effective distribution of vaccines in those poor countries where national public health systems cannot deal with the expenditures required for universal immunisation programmes.

### *United Nations Partnerships*

Establishing a global partnership for development is a top priority of United Nations, embedded in the UN Millennium Development Goals list since 2000. Thus UN aims also at working in cooperation with the private sector, in order to make available the benefits of new technologies—especially information and communications technologies.

The World Health Organization has pioneered the recourse to strategic coalitions in order to deal with health emergencies. Throughout the last decade, the number of partnership projects has exponentially increased, initially due to the growing interactions of the UNICEF and the WHO with private partners. Drawing the attention of both public opinion and international institutions towards the demand for global action, a number of global alliances established for fighting infectious diseases pandemics -such as HIV, polio, malaria and tuberculosis- have demonstrated the relevance

of joint efforts in emergency situations. Established in 1994 by a resolution of the UN Economic and Social Council and launched in January 1996, UNAIDS (Joint United Nations Programme on HIV/AIDS), is a joint venture of the UN system which aims at fighting the AIDS pandemic by operating to accomplish a set of goals, such as prevention, treatment and funding in order to halt the spread of HIV/AIDS. UNAIDS includes ten organisations of the UN system, namely WHO, UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, and the World Bank.

In trying to understand the characteristics of the GPPPs pattern outlined by the UN system, we can at this point focus on a concrete case of UN partnership.

In 2003 WHO and UNAIDS launched together the '3 by 5' initiative, a joint strategy which aimed at providing antiretroviral therapy (ATV)<sup>2</sup> to three million people with HIV/AIDS in low and middle-income countries by the end of 2005. The alliance promoted a broad range of relationships, including 'national and local governments, civil society, bilateral donors, multilateral organizations, foundations, the private sector (as employers and as treatment implementers), trade unions, traditional authorities, faith-based organizations, nongovernmental organizations (international and national) and community-based organizations' (WHO, 2003). Its strategy also supported the integration of HIV/AIDS responses within a comprehensive strengthening of national health systems.

Surprisingly, a major implication of its five pillar strategy, is that the '3 by 5' mission does not directly supply medicines. It is rather committed to raising funds, encouraging national engagement towards ATV coverage, developing global alliances, coordinating existing networks of medicine supply, and implementing communication systems in order to share knowledge and experience. This issue will be discussed below. For now, we want to explore the role of GPPPs by investigating on different approaches of global social policy. The main hypothesis of this paper is that current patterns outlined by global public-private health partnerships here examined can be classified at least in two different ways, namely according to methods of targeting recipient countries and to their governance structure.

### *Targeting models*

A first kind of classification may be conducted distinguishing the model described by the UN

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<sup>2</sup>Antiretroviral therapy prolongs lives, reduce HIV transmission and help restoring quality of life.

partnerships (such as the '3 by 5' programme) from the GAVI pattern by focusing on methods of targeting interventions to recipient countries.

The discussion on whether social inclusion can be best achieved through selective or universalist approaches has been recently reviewed with respect to the health policy. While a selective targeting of recipients with the highest socio-economic risks can fail in providing health protection to people in need, it has been suggested, universalism do not necessarily help reducing health gaps because it does not consider basic social and economic inequalities (Mackenbach et al., 2002). In this view, a distinction between universal and more selective models can help discerning underlying partnerships patterns by considering the different extent of concrete support. Despite ongoing transformations, as Deacon argued (2000), the overall rationale which underpins most global institutions does not concern social protection as a means of social redistribution.

Anyway, when inspired by universalism logics, it can be argued, global institutions can either engage with a less broad-based mandate or have to reduce its target according to the residual-oriented approaches of private partners and financial institutions. While the '3 by 5' project is clearly embedded in the path towards the universal coverage, the GAVI paradigm seems to reflect the latter strategy. The WHO partnerships - and the ones of social agencies of the UN system – have undertaken a broad engagement with global targets such as Health for All and '3 by 5'. Though not completely fulfilled, UN objectives aim at providing health care to everyone, reproducing a principle of equity and of universal commitment. UNAIDS and WHO adopt a non selective logic: each country may benefit from the '3 by 5' support and no eligibility criterion has been established. It is clearly stated that 'WHO responds to and provides assistance to all countries that are committed to scaling up treatment' (2007). UNAID co-ordinates national services and global donors aid in order to promote the definition of national plans of coverage in line with the '3 by 5' initiative. Therefore, the public-private partnership model of '3 by 5' comprises only symbolic, technical and political leadership of the public actors whereas financial support is provided by external donors. Contrarily, GAVI adopts a selective approach which limits the intervention exclusively to specific target groups, namely high risks states. GAVI directly finances and supply vaccines, though with the technical assistance of UNICEF and WHO. Nonetheless, there is a growing concern over GAVI eligibility criteria, which are based on national income, providing support only to countries with average annual per capita income below \$1000. In addition, further preconditions are applied to countries asking for support: a comprehensive Multi-year Plan for Immunisation in place; existing mechanisms to co-ordinate Ministries of Health and donors; submission of a recent review of

national immunisation provision. Although GAVI still clearly underlines 'the belief that all children – no matter where they live – deserve a healthy start is the foundation of GAVI' (2007), its selective criteria manifestly exclude countries which have no immunization coverage and poor families in middle-high income countries. For example, GAVI vaccines and systems support are determined by national coverage rate for diphtheria, tetanus and pertussis. Public health observers strongly recommend that GAVI focuses more on most vulnerable children, who frequently live in poorest areas where the immunisation system does not function (Heaton and Keith, 2002). A further residual principle is applied to the content of the GAVI support which, as it is argued below, is primarily focused on supplying targeted immunisation coverage.

### *Governance structures*

A second, crucial distinction of GPPPs patterns concerns the different models of governance which are outlined by informal and formal participation of non-state actors in the decision making process of such partnerships. Given the evolving definition of governance, we can overall define it for now as a process which encompasses formal and informal norms, rules and decision-making procedures that bring order and structure co-operation (Buse, 2004). It is also true that different interpretations of the concept, such as the one proposed by UNDP, have a broader perspective, which comprises 'mechanisms, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences' (UNDP, 1997). As it will be discussed below, to a certain extent, the UNDP definition also reflects a broader concern of the UN GPPPs towards the risks of excluding civil society from the decision-making process.

WHO and UNICEF alliances have frequently experienced episodic operational interactions with the private sector and successful collaborations with non-profit organisations. Such forms of collaboration frequently provide for a strong external technical and financial aid of the private partner, which may maximise the impact of the initiative without undermining the decisional power of member states. This model of partnership concerns both experiences of collaborations with private companies and with non profit actors, such as research institutes, foundations and civil society associations and it has been defined in terms of 'a collaboratory agreement between one or more partners of the UN system and non state actors' (Ollila, 2003).

The '3 by 5' initiative is a broad alliance and the role of non-state actors is considered crucial,

though it has not been formally embedded in the governance structure of the alliance. This means that a number of partners and organisation have been included in programme development and service delivery at global and countries levels, without undermining the leading role of UNAIDS in coordinating and preparing targets and indicators. By the end of 2005 the '3 by 5' initiative has provided ATV treatment approximately to one million people, doubling the overall initial coverage of 2003. This work does not aim at assessing the impact of global health initiatives but it rather attempts to identify links between partnerships patterns and obstacles to the achievement of global public health goals. Anyway, further challenges, it is noted, still need to be addressed in order to achieve the ultimate goal of universal access to ATV therapy by 2010, as G8 members have proposed in 2005. According to current reviews, a number of hurdles which emerge from first assessments of the '3 by 5' initiative could be reduced with a more efficient coordination of the partners involved. For example, it is said, the number of donors involved in the treatment delivery has a direct impact on the local capacity of managing procurement mechanisms (Hardon and Daniels, 2006) and major difficulties originate in the implementation of the treatments at the local level, due to inefficient infrastructures. Nonetheless, such problems do not seem to be attributable to decision-making procedures. It is frequently rather been questioned the overall international strategy towards the universal access to ATV and the lack of both political engagement and a global consensual definition of concrete targets to achieve.

Contrarily, arising debates on GAVI are increasingly expressing scepticism about the governance structure and the role of the private sector in shaping priority setting within the board. In 2003 GAVI created the Executive Committee to enhance the strategic decision-making abilities of the Board. It includes a group of four renewable members of the Board and four additional members – one rotating member each from developing and industrialized country governments and one rotating member each from industrialized countries and developing countries vaccine industry. In other words, this means that the private sector, namely the representatives from the vaccine industry, is officially represented on the Board and in the Executive Committee as an equal partner. To some extent, the full membership of the donors can be coherently explained since the concept of partnership itself presumes it. So, it could be said, why are GPPPs like GAVI arousing growing interest and scepticism? Why is the extent to which this governance model represents a positive innovation being questioned? (Richter, 2004).

Firstly, scholars investigating on GAVI suggest that such structures of the governing bodies have

been deliberately established to represent interests of the private sector (Buse, 2004). Therefore, concerns are being expressed about its system of prioritisation. It is claimed that risks of conflict of interest may arise, given the presence of the pharmaceutical industry on the GAVI Board (Hardon, 2001; Muraskin, 2004) and considering the procedures of allocation of financial resources within it. For example, results from countries reports revealed that almost 90% of the huge initial private donation fund has been addressed towards the introduction of new and underused vaccines. In the case of the year 2000-2001 the main part of those funds has been destined for the introduction of the vaccine against hepatitis B. Furthermore, a detailed report of recipient countries experiences suggested that selected vaccine combination have frequently been supply rather than demand-led (Starling et al., 2002). By the end of 2006, overall assessment of GAVI global performance shows that 28 million additional children had been protected with basic vaccines whereas 138 million additional children had been protected with new vaccines (GAVI, 2007). By prioritising the introduction of new and underused vaccines, provided by donors, over the Expanded Programme on Immunisation against fatal preventable diseases proposed by WHO<sup>3</sup>, GAVI is raising concerns about an important political dismissal in global health policy of the universal coverage objective, prioritised by WHO as a milestone in pursuing the Health for All target. Such direction seems to outline a major attention to the technical innovation to the detriment of primary health care which has been summarised in the expression 'health market for all' (Deacon, 2000). At the same time, this shift demands further debates about the role and accountability of non-state actors in global social policy (Heimans, 2006). One main question concerns the overall weakening of the UN system whose values and overall mission seem to be undermined by 'multiple agendas' within UN-business partnerships (Utting, 2000).

In this regard, a further, major perspective concerns the role of civil society in GPPPs initiatives. This is a relevant issue, both for the formal representation of civil society representatives and for the concrete participation of the local communities in the definition of national health priorities. This theme also concerns a broader discussion on the role of top-down global initiatives in meeting local needs. Community support and establishment of bottom-up engagement, it is said, may lack when GPPPs goals are not defined in conjunction with recipient countries. The UNAIDS governance is guided by a Programme Coordinating Board with representatives of 22 governments from all geographic regions, the UNAIDS Cosponsors, and five representatives of non-governmental organizations, including associations of people living with HIV/AIDS. The adopted strategy is

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<sup>3</sup>EPI is a programme of vaccination against six main preventable childhood diseases: diphtheria, pertussis, tetanus, tuberculosis, polio and measles.

directed towards coordinating the work of UNAIDS cosponsors organisms in order to elude cases of overlapping interventions and to enhance transparency mechanisms of its policies. UNAIDS is the only UN entity with NGO representatives on its Executive Board (UNAIDS, 2006).

Besides including one rotating member from NGOs in its Board, GAVI has also recently focused on a broader involvement of civil society representatives, proposing the establishment of a Civil Society Task Team. Purposes of the mentioned Task Team seem to concern activities of implementation, coordination, monitoring and communication with GAVI. Though crucial for the formulation of a coherent strategy of action, such tasks do not comprises a greater involvement of local civil society in the decision-making process. To a certain extent doubts expressed about the 'global' dimension of these initiative must also be taken into consideration. UNAIDS and WHO are currently working in order to develop 'south-south' collaborations which may establish more efficient regional coordination, whereas representatives from the civil society included in the GAVI Board are frequently NGOs from developed countries. Furthermore, it is also noted, the overall political importance of these initiatives may be undermined because GPPPs headquarters are located in developed countries and concrete participation of partners may be difficult to achieve. As a result, the representation of south governments and civil society can be more realistically wielded in terms of local interests and perspective (Buse, 2004). Although several remarkable cases of non-formal interaction with local communities must be recalled, a formal political representation of local civil interests still appears relevant in order to prevent the risk that the over-representation of corporate and expert communities may undermine the interests of civil society.

As this brief description have demonstrated, global health policy still appears profoundly unstable although potentialities of mutual exchanges and the positive overall contribution of different alliances to global campaigns must be considered. It is clear that current trends in the GPPPs organisation models have not yet established definitive patterns. Nonetheless we can use the cases presented here in order to contribute to the general discussion on the role of GPPPs by identifying at least two different models. The '3 by 5' initiative can be defined as a '*soft*' version of GPPPs. Targeting methods and governance structure seem to describe a strategy which opts for a wider project of universal health to the detriment of short run impact. The institutional role of UNAIDS and WHO is preserved: they do not need to deal with 'multiple agendas' of the business partners, who are not officially included in the governance structure and, apparently, are not involved in the



decision-making process. Contrarily, the selective focus of GAVI both on specific targets of immunisation and on eligibility requirements allows a more concrete support to recipient countries. As a result, this strategy entails a shift in the role of global institutions which have to share their agenda with corporate interests. Such distinction between 'hard' and 'soft' patterns of GPPPs is obviously only intended to help interpreting the debates here described and cannot be regarded as definitive. Firstly, observers have noted that UN GPPPs reveal a significant lack of specificity in defining partners roles, status and accountability (Buse, 2004). Therefore, different governance schemes between UN and the private sector must be considered because they can create further patterns of GPPPs. The UN strategy, furthermore, is gradually being weakened by closer relationships with the private sector. As Utting argues (2002), though the evolution of UN-business partnerships is unpredictable, big business seems to be favoured since 'self-censorship' of UN agencies is increasingly occurring. For example, while few years ago WHO formulated explicit recommendations about the need to prioritise the Expanded Programme on Immunisation against fatal preventable diseases, its attention is recently been addressed both to an overall increase of the traditional immunisation coverage and to the introduction of new vaccines. Anyway, concerns arises both from the '*soft*' and the '*hard*' pattern. While the former demands further investigation about the overall deterioration of the leading role of the international institutions in the global policy, the latter suggests to consider the risks of privatisation and commercialization of the UN system. Moreover, both the patterns must face the challenges which originate in different goals and agendas that can be difficult to co-ordinate. As several authors put it, global health partnerships will unlikely deal with a long-term public health strategy because it would not interest pharmaceutical companies. Accordingly, further interactions with the private sector will only be feasible if global institutions dismiss either their political leadership or part of their agenda. At the same time, the experiences of GAVI and '3 BY 5' revealed that major achievements can derive from the interactions with philanthropic associations, whose financial and scientific contribution has developed new strategies of action for dealing with several health emergency situations<sup>4</sup>. Global health coalitions such as GAVI and '3 by 5', regardless of their limits, have unquestionably gathered disconnected endeavours and strengthened the impact of national and international policies, thanks to a huge common background of consultation and collaboration.

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<sup>4</sup> The latest reports have recorded that endemic transmission of polio have been eliminated in all but four countries. (WHO, 2006).

## Conclusion

The scenario here described suggests that this background, as well as the current forms of public-private interactions, should be preserved and enhanced in order to improve transparency and equity mechanisms. One of the key future challenges for GPPPs will concern the development of more equal systems for involving the global South so that *recipient* countries may assume the status of *partners*. In this regard, while main responsibilities are related to the political decisions that national governments will undertake in the near future, a reform of the United Nations system seems inevitable, in order to provide global social and health organisms with the authority which the global regulation of social protection demands. Global health topics urgently necessitate institutional commitments as well as political will and effective strategies of action. Nevertheless, a major change in the mechanisms of global coalitions could be engendered through a gradual process of reform. Progresses reported in the establishment of supranational governance connections can provide a successful example of a gradual regulation of transnational health issues from the regional scale to the global level. The major activism of transnational civil society movements could, furthermore, help introducing health issues in GPPPs agendas so that global interests from both the North and the South of the world can be represented.

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