

UNEDITED DRAFT

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PUBLIC/PRIVATE PARTNERSHIPS IN THE PUBLIC HEALTH SECTOR

INTRODUCTION

The nature of global health has changed dramatically in the past two decades, bringing in new actors to expand responses to global health needs, including service delivery, prevention, and research and development of new medicines, especially for neglected diseases. Besides governmental activities, the involvement in health of nongovernmental organizations, private health providers, commercial companies, philanthropic foundations and civil society has constantly increased. Few successful initiatives in public health can rely on a single organization nowadays. The consequent multisectoral engagement and multiplicity of stakeholders have introduced new requirements for the effective management of these interactions and prompted a lively debate on the features and principle of a "global health architecture".

The proliferation and increasing popularity of public-private partnerships during the last 10 to 15 years has been one of the main manifestations of this development. Public health has been a pioneering field for the establishment of innovative and hybrid forms of international cooperation and governance. There are many definitions of public-private partnerships, and the fact of using the same label to designate rather different phenomena has not helped clarity and rigour in academic and policy analysis. Within the United Nations, in particular since the launch of the Global Compact in 2000, "partnership" with the private sector is used to designate "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 and to share risks and responsibilities, resources and benefits."¹ While this concept is certainly applicable to the partnerships that have emerged in the field of public health, the latter have often developed a distinct identity, separate governance systems (or at least coordination mechanisms), hybrid forms of international policy-making, and innovative legal tools that distinguish them from the perspective of global administrative law. This paper, therefore, will focus on health-related public-private partnerships (PPP) with particular institutional or governance features rather than more generally on international public-private cooperation to achieve health goals.

This paper will also focus on the role played by the World Health Organization (WHO) in such a development, and its implications for the Organization. WHO has a long tradition of institutionalized cooperation with other actors, especially for the pursuit of goals that did not attract sufficient financial resources or required special forms of inter-agency coordination or a joint approach due to the particular nature of the health issue involved. These joint or co-sponsored programmes, however, were limited to UN-system organizations and established steering or coordination bodies open almost exclusively to WHO Member States. Recent PPPs have confronted WHO with the new challenge of engaging and assuming long-term commitments with a variety of different actors, public and private, through voluntary and horizontal models of governance

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¹ UN Document A/60/214, p.4.

characterized by the fundamental equality of all participants. WHO has also taken the additional challenge of hosting some of the partnerships and thus of integrating them into its own governance while respecting their separate identity.

ORIGINS AND MAIN MODELS OF PPPs

As noted above, the proliferation of long-term, cooperative and institutionalized alliances of national governments, NGOs, international agencies, commercial companies, philanthropic foundations and other entities, such as research institutes, has emerged since the late 1990s as a growing phenomenon in the field of international public health cooperation.

The reasons for such success and popularity are manifold, but a few should be highlighted:

- The effects of globalization, with a relative retrenchment of the public sector, the overall reduction in government spending for development assistance and the growing role of private actors in various fields of public health, both at national and international levels.
- The failure of the market to address the yawning gap between mortality and morbidity trends in developing countries on the one hand, and the resources dedicated to the medicines necessary to reverse those trends. It is not a coincidence that several partnerships have been specifically established to address this fundamental inequality and remedy the inadequacy of the market.
- A lack of confidence in the capacity of international agencies (especially WHO and UNICEF) to mobilize the resources and the political will to tackle effectively a number of chronic health problems in developing countries such as malaria, HIV/AIDS, maternal and child mortality, the availability of affordable vaccines etc.
- The inability of the governance of current intergovernmental organizations to ensure participation of emerging actors in public health, in particular commercial companies and large philanthropic foundations, in policy-making.
- The possibility for major donors, public and private, of "controlling" and shaping more closely cooperative activities through small and dedicated structures rather than through the mainstream governance of existing institutions.

A brief description of some of the most institutionally and functionally interesting public health partnerships may help in appreciating both differences and commonalities:

1) The Global Alliance for Vaccine and Immunization (GAVI Alliance) was launched in 2000 thanks to an initial grant by the Bill and Melinda Gates Foundation. The main objective of the GAVI Alliance is to improve access to sustainable immunization services in low-income developing countries through the mobilization of substantial new funding from both public and private sources. The GAVI Alliance was initially established as a non-incorporated initiative hosted by UNICEF. In order to attract corporate donations, a separate "GAVI Fund" was established in the United States as a tax-deductible foundation under the US Federal Tax Code. As a result of a decision to converge GAVI's overall governance in 2004, the Boards of both institutions started holding joint meetings and appointed the same person as chief of both secretariats. Starting in 2006, a thorough revision of GAVI's governance led to a decision by both Boards to merge the Alliance and the Fund into a single entity, incorporated as a foundation under Swiss law. This was

accomplished on 1 January 2009, when the hosting arrangement between UNICEF and the Alliance was terminated. The GAVI Alliance is essentially a financing institution, which aims at scaling up financing for vaccines both through the commitment of its members as well as through innovative financing schemes that will be reviewed later in this paper.

2) The Global Fund to Fight AIDS, Malaria and Tuberculosis was established as a Swiss foundation in 2002, as a result of the momentum generated by the G8 summit in Okinawa (2000) and the UN General Assembly special session on HIV-AIDS in 2001 for raising large sums of money to complement other resources to fight AIDS, TB and malaria. It addresses gaps in country efforts to fight the three diseases, strengthens health systems by financing programs that complement those of other donors, and seeks to use its own grants to stimulate further investment by both donors and recipients. The Global Fund has developed a rather elaborate governance structure and operational approach: its steering body is a Board composed of constituencies representing both governments and private stakeholders including civil society and a private sector representative, supported by several committees of similar composition. Eligibility for its grants depends on the existence of a Country Coordinating Mechanism in recipient States and on Local Fund Agents, private consulting firms that provide a financial assessment of the intended Principal Recipient of the grant as well as oversight on its performance. Even though the Global Fund was established since the outset as a separate legal entity, WHO provided administrative services, including notably its Secretariat, through an administrative service agreement. The agreement was terminated at the end of 2008 and the Global Fund is now a completely autonomous institution.

3) UNITAID is an international drug purchase facility established in 2006 on the initiative of Brazil, Chile, France, Norway and the United Kingdom as an instrument to mobilize long-term, secure and predictable resources through innovative funding approaches. In particular, France and a few other partner countries used an airplane ticket tax as an economically neutral tool whose revenues are almost entirely contributed to UNITAID. UNITAID addresses the same 3 diseases as the Global Fund but does not make direct grants to governments or other recipients, instead financing project by partners such as UNICEF and the Bill Clinton Foundation. All projects must have an anticipated impact on markets, by leveraging price reductions, encouraging the manufacture of user-friendly new products or speeding up drugs availability. By guaranteeing sustainable predictable revenues for the purchase of drugs, UNITAID plays an important role in influencing manufacturers, reducing prices and developing neglected niches of the market such as that for pediatric medicines. UNITAID also aims at stipulating competition by supporting WHO's prequalification of new medicines and attracting new manufacturers. Its governance is mainly based on a very active Board of 11 members, consisting of participating governments, civil society networks, foundations and WHO, which also serves as the host organization for UNITAID. In 2008, UNITAID supported and funded the preparatory process for the establishment of a charitable foundation to implement the Voluntary Solidarity Contribution project based on voluntary donations by on-line purchasers of air tickets. Resources to be generated through this scheme will be for the most part contributed to UNAIDS.

4) The Stop TB Partnership, established in 2000, is not a financial instrument such as those mentioned above but rather a platform for public or private institutions dedicated to the elimination of TB to coordinate their respective actions, advocate and promote a number of measures to achieve their ultimate goal. The Stop TB Partnership has

developed into a successful exercise in social mobilization, which has expanded to include more than 1000 institutions worldwide that occasionally gather in a Partners Forum to review progress and increase support for the Partnership. Once again, executive and strategic functions are carried out by a Coordinating Board of 33 members which include the chairpersons of the seven thematic working groups established by the Board itself as well civil society and a commercial company (currently the French company bioMerieux). Stop TB is hosted by WHO and has developed specific tools, which are closely integrated into WHO's structure, to support countries in accessing TB drugs and diagnostics.

5) The Medicines for Malaria Venture (MMV) was established in 1999 as a Geneva-based foundation. MMV's mission is to bring public, private and philanthropic sector partners together to fund and manage the discovery, development and delivery of new medicines for the treatment and prevention of malaria in disease-endemic countries. MMV was conceived as a "public venture capital fund" because of the failure of the market to provide the required incentives for wide scale R&D in new malaria medicines. It operates more like a small virtual R&D company than a public scientific funding agency, hence the need for an independent legal structure and governance, consisting mainly of a 12-member Board and a scientific committee which advises the Board on the selection and review of candidate products to fund.

Other partnerships and collaborative arrangements which play a significant role in international public health cooperation and that will be mentioned in this paper are the Roll-Back Malaria Partnership (RBM), the Health Metrics Network (HMN), the Global Health Workforce Alliance (GHWA), the Partnership for Maternal, Newborn and Child Health (PMNCH), and the World Alliance for Patient Safety (PSP). They are all hosted and administered by WHO.

GOVERNANCE

From a structural and governance point of view, PPPs and similar collaborative or coordination arrangements may be roughly divided into the following categories:

- networks: loosely structured groups whose participants meet periodically to exchange information and views, coordinate strategies, facilitate advocacy or provide advice to participating organizations. By definition they need to be convened and supported by an existing institution, support which mainly consists in servicing the periodic meetings of partners and acting as a clearinghouse of information. Most activities are carried out by individual partners in their own name. Examples are the Safe Injection Global Network and the Global Outbreak Alert and Response Network (GOARN), both coordinated and convened by WHO;
- Programmes with external participation: these are long term, structured programmes, integrated into the Secretariat of an existing international agency and managed by it, albeit with the substantial involvement of a number of public or private stakeholders that provide guidance and evaluation through advisory bodies, as well as financial support. These collaborative arrangements are normally based on instruments such as terms of reference, strategic frameworks or guiding principles which are agreed among the participants but remain formally working documents of the convening organization. Activities are undertaken by the latter under its responsibility

- Alliances: these are highly structured initiatives which effectively function as an identifiable entity. Even though they are not separate legal entities and are hosted by an existing organization, they have an executive body with the authority to take decisions on behalf of its members and a full-time dedicated secretariat provided by the host organization, which implements most of the activities of the alliance. They are established and function on the basis of founding and procedural documents that regulate in detail the governance of the alliance, and conclude formal hosting arrangements, e.g. in the form of a memorandum of understanding (MOU), with the host organization. Partnerships mentioned above such as UNITAID, RBM and the Stop-TB Partnership fall into this category.
- Partnership organizations: These PPPs are constituted as separate legal entities, with the administrative and legal structure of a non-profit corporation or trust under national law. They have a highly developed governance structure including a governing body representing all members or relevant constituencies, with the authority to commit the institution and represent it vis-à-vis third parties. Their founding instruments depend on the legal requirements of the country of incorporation, such as articles of incorporation or deeds, and their actual legal status depends on the applicable national law or the arrangements reached with the host country. Main examples in this group are the Global Fund, GAVI and MMV.

A common characteristic of most of the partnerships mentioned above is that they are all based on voluntary arrangements of an administrative rather than international nature entered into by the partners among themselves and/or with their hosting organizations, or are loose and informal associations of institutions that join an open-structured alliance through a simple application process. The more institutionally developed partnerships under review have set up elaborate governance structures as a form of self-organization even without being established as separate legal entities.

As was noted in a recent study by the World Economic Forum ², effective governance within a PPP is a complex and multi-layered arrangement. Public and private institutions may have quite different underlying interests and expectations. Private sector partners, for example, may be concerned about the use of funds and technologies and about adequate brand recognition; public sector partners will require confidence in the motives of private sector partners and may be reluctant to accept heavy oversight over their involvement. Perceived inequalities between different group of stakeholders may consequently lead to a lack of trust and stumbling blocks. Strong and clear governance is therefore important and partnerships have often invested considerable efforts in evaluating and revising their governance arrangements, with particular regard to accountability, transparency, disclosure, participation, decision-making and performance assessment. A comparative analysis of the partnerships mentioned in this paper reveals a number of common issues:

² World Economic Forum, Building on the Monterrey Consensus: The Growing Role of Public-Private Partnerships in Mobilizing Resources (2005), p.40.

1. Type of structure. Various institutional and governance models are possible. Practical experiences shows the importance of an organizational structure that fit the goals, expectations, number of partners and complexities of every particular alliance while minimizing transaction costs. This is not a simple exercise and the problems and failures occasionally experienced by PPPs sometimes depends on the lack of an adequate organization. A recent study by the Gates Foundation ³ points to five possible structural models: simple affiliation (no formal structure, informal coordination mechanism), lead partner (one partner assuming a leadership but not dominant role), general contractor (one partner is the recognized leader and decision-maker), secretariat (a group of partners acting through a joint secretariat), and joint venture company (partners create a separate legal entity with its own staff and resources). While most of the public health PPPs fall within the latter two models, the stated goal and functions of a partnership have probably been the predominant factors in shaping its structure: where the partnership mostly plays a coordinating or policy-developing role, looser structures without strong directing bodies and secretariats have proved to be the most appropriate and cost-effective; in the case of financing and implementing partnerships, the need for stronger management and accountability frameworks leads to a demand - especially by donors - for more elaborate and centralized governance.
2. Participation. This is by definition a crucial issue in multi-stakeholders arrangements often predicated on inclusiveness, representation of all interests concerned and openness. The demand - in particular by civil society organizations - for horizontal models based on the equality of all partners and participation biased in favour of underrepresented interests (civil society groups, communities living with diseases, developing and high disease burden countries) has to be reconciled with the interest of governments for a participation model that guarantees a preminent role for public sector partners, in particular donor countries. Recent partnerships have developed a number of arrangements to address these competing interests, in particular the establishment of partners forums and a constituency approach to representation on boards and their committees. Many partnerships (e.g. UNITAID, the Global Fund, the Stop-TB Partnership, PMNCH) have established partnership forums open to all partner organizations, in particular those which may not enjoy formal board membership. Forums meet once every 2-3 years and serve as consultative mechanisms to strengthen the engagement and buy-in of the broader community of partners, raise the profile of the health issue involved, review progress and coordinate actions. Especially in the case of coordinating and advocacy partnerships (such as Stop-TB and RBM), partnership forums provide a very useful mechanism to compensate possible perceptions of inadequate representation. Several partnerships have also organized membership in their boards and committees on the basis of representation of constituencies rather than individual seats. According to a review by the UK Department for International Development (DFID) ⁴, successful alliances involve a large number of persons and institutions in dense webs of communication; allocating seats to constituencies can enable the diversity of their views to be factored into decision-making while relying on well functioning group arrangements. For example, the seats on the Board of the Global Fund are, with the exception of a few major donor countries, assigned on a

³ Bill and Melinda Gates Foundation, *Developing Successful Global Health Alliances* (2002), pp. 3-5.

⁴ DFID Health Resource Centre, *Global Health Partnerships - Increasing their Impact by Improved Governance* (2004), pp. 32-34.

constituency basis: like-minded or geographically linked donor countries; recipient countries defined on a regional basis; civil society, private sector and private foundations seats allocated on the basis of nominations from representative groupings of the various stakeholders organizations. Using this approach, membership in the Board is based on the decisions of the groups concerned which voluntarily and autonomously define their own organization, rotation, communication channels and representation of group versus individual interests. Constituencies may consist of ad hoc groupings formed for the specific purpose of managing participation in a particular partnership or of existing and external representative associations, in particular in the case of civil society and the private sector. The constituency approach, from an institutional point of view, adds an additional layer of voluntarism and self-organization in the structure and functioning of alliances which are based on those same principles; if this may increase breadth and inclusiveness of participation, it completely entrusts accountability and legitimacy considerations in the hands of diverse groups whose own accountability may in turn be dubious or at least undefined.

3. **Role of the private sector.** One of the main innovations and challenges brought by recent PPPs has been the direct involvement in their governance and participation in their activities of commercial companies - mainly pharmaceutical or vaccine manufacturers - or of umbrella organizations representing their interests. As noted above, one of the driving factors behind the emergence of PPPs has been the reconsideration of the role and impact of the commercial sector in areas of international development cooperation traditionally considered the preserve of governments and intergovernmental organizations. PPPs have served as a vehicle to enable these actors and the interests they represent to participate in decision-making and policy-setting much beyond the limited roles they play within "traditional" international agencies. For example, two seats on the Board of the GAVI Alliance are reserved to vaccine manufacturers from developed and developing countries, respectively (currently occupied by Glaxo Smithkline and the Serum Institute of India); the Board of the Roll-Back Malaria Partnership has two seats for companies active in malaria control (currently Sanofi Aventis and Vestergaard Frandseen); and the Global Business Coalition on HIV/AIDS, TB and Malaria represents the private sector constituency on the Board of the Global Fund. It was felt that, besides financial support, involvement of the private sector brings a business mindset focused on strategic planning, driving for results and targeted progress evaluation, which may benefit the activities of the partnership. At the same time, in view of the essentially public nature of the functions of partnerships and their direct impact on corporate interests, the issue of management of conflicts of interest could not be ignored. As a result, many partnerships have elaborated conflicts of interest policies to which private sector partners have to commit themselves but which are largely left to the self-assessment of the partners themselves. Another mechanism to address both potential conflicts of interest and effective representation of the private sector constituency is to delegate outreach, selection and screening to an external third party. For example, in the case of the Stop-TB Partnership, the Global Health Initiative of the World Economic Forum functions as a constituency that bridges the partnership with the private sector and selects its representative on the Board. A final comment on this point is that both commercial companies and large philanthropic foundations (such as the Gates, Rockefeller, Buffet and Google Foundations) tend to inject a corporate ethos in the vision and operations of partnerships. This finds expression, for example, in pushing for a broader

4. Accountability. This is one of the most complex governance issues in partnerships in view of the horizontal, informal, voluntary and layered nature of their structure and the absence of a vertical overall structure to ensure the accountability of partnerships as such to a higher authority. The DFID study mentioned above identifies four main lines of accountability: 1) partnership secretariat to the partners ⁵; 2) partners to the partnership; 3) partnership to stakeholders and constituencies; 4) partnership to the global health architecture. The accountability of partners to each other as well as towards the broader group of constituencies engaged with the partnership is a crucial issue for the success of a partnership but can be equally elusive in the absence of clear lines of reporting and authority. Partner accountability may be less of an issue in research and development partnerships, where most of the activities are subcontracted, but may become a problem in other cases for 3 main causes: lack of clarity about roles and responsibilities; the voluntary and informal nature of commitments and the lack of enforcement mechanisms; and the prevalence of the corporate agenda of individual partners versus the goals of the partnership, which may even lead to situations of competition (e.g. to attract funding). The DFID study recommends a number of measures to increase accountability within such a voluntary legal environment, such as strategic alignment around a shared global strategy; coordinated work planning and joint reporting and review; specific partnering practices and development of informal relationships; "name and shame" sanctions to deter non-compliance; and conclusion of legal arrangements such as MOUs to increase accountability for specific commitments or transactions.

FUNCTIONS

A review of the functions and activities of PPPs in the field of health is beyond the scope of this paper. In general, they have been established to expand health interventions in a flexible and focused way, mobilize new resources, develop and introduce innovative technological solutions where public and market forces have failed; enhance coordinated actions among partners; and mobilize a broad spectrum of groups and social forces towards a common goals. An analysis of the goals of public health PPPs points to three main general missions and functions, while recognizing that the activities of some partnerships straddle between these categories:

1. finance developing countries' health programmes with a view to extending coverage of certain interventions or to strengthening their health systems (Global Fund, GAVI, UNITAID)
2. coordinate the actions of diverse partners around specific diseases or health conditions (PMNCH, RBM, Stop-TB)
3. research, including strengthening capacity, and acting as a catalyst for the development of new products, e.g. medicines, vaccines and diagnostics (MMV, Drugs for Neglected Diseases Initiative (DNDI), International AIDS Vaccine Initiative (IAVI))

⁵ The accountability of the secretariat is a particularly delicate issue for hosted partnerships and will be reviewed below with specific regard to WHO.

One interesting element of the activities of PPPs, especially those involved in financing as well as product development, is the use of private or market-oriented instruments as an integral part of their operational approach. This flexibility represents undoubtedly one of the advantages of partnerships in their present form, as a similar approach would be virtually impossible for international agencies.

The use of market instruments is particularly crucial for partnerships which aim at encouraging the development of new medicines and/or vaccines for so-called "neglected diseases" or to expand availability and affordability of existing ones. The failure of existing market structures to create sufficient incentives for manufacturing companies is, as noted above, one of the main reasons for the establishment of public health PPPs⁶. Partnerships have used a variety of "push mechanisms" providing direct funding for research as well as "pull mechanisms", i.e. incentives designed to create or secure a market thereby improving the likelihood of a return on investment.

A push mechanism is used by the Medicines for Malaria Venture (MMV). In view of its focus on the discovery and commercialization of new drugs in the face of an inertial pharmaceutical market, MMV operates by funding projects on a competitive basis. Applicants are required to sign an initial letter of intent, are made aware that continued funding depends on progress and on maintaining competitiveness with other MMV-funded projects, and are subject to regular review and scrutiny to assess progress. It has built a large 'drug portfolio', and four new anti-malarial drugs are expected to reach registration by the end of 2009. One distinctive element of MMV is the use of intellectual property rights as a strategic element of its operations, so as to ensure some control over the eventual development of new drugs. The balance between ensuring an adequate return for participating companies and the affordability of the new drugs for developing countries revolves around the public source of funding, the non-for-profit nature of MMV, and the selection of appropriate intellectual property rights. In view of MMV's work mainly with large companies, which are not required to make substantial investments in R&D projects, the Venture secures downstream rights to develop compounds, either through patent ownership or through a free licence on drug-development candidates that result from the research project. The main condition, in any case, is that MMV retains the right to take over development should a particular commercial partner withdraw.

In contrast, a pull mechanism called "Advance Market Commitment" (AMC) is utilized by the GAVI Alliance to stimulate the development and manufacture of vaccines specifically for developing countries. AMCs relate to donor commitments for future purchase of a specific vaccine and/or medicine, not yet available, at a price that will assure the drug developer a profitable return. Positive effects of such a mechanism are threefold: first, poor countries will benefit from new drugs to fight against diseases that seriously affect their population; second, the pharmaceutical industry will be able to perform research and development in fields that, without such a donor commitment, would not be profitable; and third, donors do not need to divert funds in advance, since they will be requested to pay once the new drug has been developed and manufactured. Two pilot projects are underway for the production of vaccines for pneumococcal disease and malaria as the most suitable candidates. To implement the AMC pilots, rather complex legal frameworks containing obligations for participants and implementation

⁶ An excellent analysis of the role of public funding and PPPs in stimulating R&D for neglected diseases is in D. Webber & M. Kremer, Perspectives on Stimulating Industrial Research and Development for Neglected Infectious Diseases, Bulletin of the World Health Organization 79 (2001), pp. 735-741.

details need to be elaborated. Such frameworks will specify the market size of the AMC, the price and the requirements of the targeted vaccine, as well as the financial commitments and the obligation to enter into a guarantee and supply agreement with any qualifying manufacturer.

A different use of market mechanisms has been made again by the GAVI Alliance to rapidly generate substantial and additional financial resources to scale up immunization programmes in developing countries. This financing mechanism was set up in 2006, largely at the initiative of the United Kingdom, and is known as the International Finance Facility for Immunization (IFFIm). Its structure and operation are too complex to be described here, but in essence they are based on long-term pledges by a group of donors which are used as collateral to securitize the issuance of bonds on the international market.

Proceeds from bonds generate substantial financial resources up front, in addition to the contributions pledged by the donors. IFFIm's institutional mechanism is centered on the IFFIm Company, a non-profit corporation established in the United Kingdom which oversees the treasury functions and related accounting services provided by the World Bank, in its capacity as IFFIm's Treasury Manager. The former GAVI Fund, which was a separate legal entity of a private nature until the end of 2008, was responsible for the establishment of both the IFFIm Company as well as a UK-based GAVI Fund Affiliate, which receives the deeds of grants from donors and assigns them to the IFFIm Company to proceed to the issuance of bonds. The GAVI Secretariat supported administratively the entire scheme. Three bond issuances between 2006 and 2009 have generated almost \$ 2 billions, which have substantially increased the resources available to the GAVI Alliance.

The use of a financial market mechanism based on a complex web of transactions and corporations created ad hoc to support the scheme is an extreme example of the flexibility enjoyed by PPPs whose hybrid and tailor-made governance, as in the case of GAVI, enables them to operate at the intersection of public and private law instruments.

THE ROLE OF WHO

WHO's main constitutional function as the directing and coordinating authority in international health work, and many Health Assembly resolutions, provide a strong legal basis for WHO's involvement with a variety of stakeholders in the pursuit of its objectives. This includes its engagement in PPPs, even in the absence so far of a specific policy on this issue. WHO's most recent strategic and planning instruments, in particular the 11th General Programme of Work and the Medium-Term Strategic Plan 2008-2013, explicitly direct WHO to engage in partnerships as a form of leadership and direction.

WHO's engagement in PPPs has two aspects: as a member of the partnership on a strategic and technical level together with other partners; and on an administrative level by accepting to host non-incorporated partnerships and providing their secretariat. On a technical level, WHO's engagement with partnerships has sometimes been the outcome of a strategic decision to take the lead in proposing new cooperative arrangements to complement existing activities (as in the case of the GAVI Alliance), and sometimes a reactive decision under pressure from donors or when confronted with initiatives largely taken outside WHO that were perceived as threatening to sideline the Organization (as in the case of the Global Fund or UNITAID). This situation has not always enabled the WHO Secretariat to guide the establishment and development of partnerships, with the result that some of them either duplicate functions already implemented by WHO (as in the case of RBM) or even compete with it for limited financial resources (as in the case of

the Water and Sanitation Cooperative Council, a partnership hosted by WHO). This has probably been one of the most challenging developments for WHO in the global health landscape: rather than being considered as the supreme international authority for the purpose of its engagement with other stakeholders, PPPs have confronted the Organization with a fundamentally horizontal approach, where other partners perceived WHO as an important partner but not as an accepted leader, and actually feared that the partnership would be dominated by WHO in the setting of its strategic agenda and priorities. This development has generated tensions both within the Secretariat and among Member States.

From a legal and institutional point of view, the most significant function is that of WHO's hosting of partnerships. The fundamental principle followed by WHO is that it would only accept to host partnerships of which it is a full member, so that administrative support would be a corollary of strategic and technical engagement. WHO may therefore be at the same time a member of the partnership's Board and thus partake of the "corporate identity" of the partnership and participate in its decision-making as a technical partner in its own right, contributing to the implementation of the partnership's workplan alongside other partners; and the host of the partnership, expected to support it and protect its interests. While this has not raised problems in some cases and has been seen as a natural corollary of being a partner, it has on occasion been challenged as embodying a potential conflict of interest and leading the Organization to take different positions on the same question, since different parts of the Secretariat may give different weight or priority to such different roles, with occasional tensions between management and technical units.

By hosting a partnership, WHO accepts to provide its secretariat as well as administrative and management functions and services in support of the work of the partnership, for example, financial management, trust fund arrangements, procurement, contracting as well as office space. In the cases of partnerships having a more developed governance system, this has sometimes been accomplished through the conclusion of a Memorandum of Understanding to regulate the hosting arrangement. Under such arrangements, a secretariat unit is established within WHO specifically to support the partnership, act and contract on its behalf, service the meetings of its "governing bodies" and, in many cases, provide technical assistance in its name. Whenever WHO provides secretariat support, staff of the partnership secretariat are staff members of WHO and enjoy the privileges and immunities granted to WHO officials in the performance of their functions. Consequently, WHO accept to assume liability for acts performed in its capacity as host for the benefit of the partnership.

WHO's practice in hosting partnerships has raised a number of legal and institutional issues, in particular the following:

1. Double governance. By hosting a partnership, WHO accepts that its Secretariat be functionally accountable and report to the partnership board while remaining accountable to the Director-General from an administrative point of view. Partnership boards typically take programmatic decisions such as adopting the workplan and budget of the partnership, and the partnership secretariat is expected to implement its decisions and be accountable to it. This arrangement raises constitutional issues, since under Article 37 of the Constitution WHO's staff may not seek or receive instructions from any authority external to the Organization in the performance of their duties. The conundrum has been partly solved by requiring that WHO be a full member of the partnership board so that

2. Hosting the partnership versus hosting the secretariat. By hosting the partnership, WHO bestows legal identity and gives institutional substance to what otherwise would be an initiative of a group of stakeholders. At the same time, albeit not being a separate legal entity, a partnership inevitably assumes a common operational and branding identity and takes decisions through its board which may be of a very substantive nature. The governance of a partnership, which can be quite elaborate, is not part of WHO's governance; WHO is a member of the board and participates in its decision-making alongside other members. For this reason, some partnerships have objected to the concept that WHO hosts the partnership, considering that WHO as an institution only hosts the partnership's secretariat while the board and its subsidiaries are independent of WHO and not subject to its rules and principles. WHO has resisted these attempts as the governance of a hosted partnership and the policies it adopts are not neutral for WHO; its close interaction and association with the partnership – both as a member and as a host - would become impossible should the partnership board operate in a way incompatible with the fundamental principles of WHO as a UN-system organization (e.g. inviting the government of Taiwan to join it) or adopt decisions grossly inconsistent with the policies and standards set by WHO as a policy-setting agency (e.g. advocating or funding treatments or medicines that WHO has rejected or recommended against). To this purpose, the activities of partnerships should be limited so as not to raise such issues, otherwise WHO should not accept to host them. For example, partnerships should neither engage in standard-setting or policy-setting, nor in technical cooperation at country level.
3. Separate entity issues. As noted above, some hosted partnerships have developed strong and active governance arrangements and acquired an equally strong corporate identity and independent mindset. They perceive their relationship with WHO as a purely administrative one and try to minimize the visibility and involvement of WHO in the work of the partnership secretariat, which consequentially perceives itself as being itself “independent” from WHO. Moreover, in some cases the programmes and activities of partnerships are not closely integrated with WHO's programmes as approved by the Health Assembly in the programme budget, even though they fall within WHO's constitutional mandate and arguably contributes to the strategic objectives that form the basic infrastructure of its work. This overall situation has generated the impression that some hosted partnerships are simply connected to WHO to receive administrative support but do not contribute to the effectiveness of its functions, instead leading to a fragmentation of its constitutional mandate and diverting limited financial resources from the Organization. It has also raised delicate issues concerning WHO's relationship with Switzerland as its host country. The Swiss authorities have informally advised the WHO Secretariat that they consider the hosting of partnerships that represent themselves as separate from the Organization as not consistent with WHO's host agreement, under which the Swiss Federal Council

4. Nature of the hosting arrangement. As noted, the decision to host a partnership has been formalized in several cases through the conclusion of an MOU which spells out the terms of the arrangement. The MOU is normally signed on behalf of the partnership by the chairperson of the partnership board. This practice raises some unresolved legal questions that are typical of partnerships: since the partnership is not a separate legal entity responsible for its obligations, what is the legal significance of an MOU? Who is bound by it on the partnership's side in the absence of a separate legal undertaking among partners to accept responsibility for acts performed in the name of the partnership? Who incurs liability in case of actions carried out by a partner or by the host organization on behalf of the partnership? Could it be argued that there is joint and several liability of the partners? But what about the common case of constituency representation, where the board members loosely represent an underlying grouping that has not participated directly in decision-making? Could it be argued that there is an agency relationship between the constituency and its representative so that the members of the constituency may be held liable for decisions taken by their representative? These are very practical questions, especially with regard to PPPs engaged in potentially risky activities, such as financing research and development of new medicines. In the case of UNITAID, the hosting MOU with WHO has been exceptionally signed by the five founding countries which have accepted to indemnify WHO in case of claims arising from transactions entered into for the benefit of UNITAID. Other MOUs do not contain indemnification clauses, which may create a difficult legal vacuum in case of claims against WHO. In future perspective, a risk assessment should be an integral part of the process leading to a decision to host a partnership. Such an assessment should be based on the purpose and activities envisaged and on the requests by the partners in terms of governance. Moreover, WHO's board membership and minimizing deviations from its normal accountability framework are both of crucial importance to minimize the risk of decisions creating unjustifiable risks and drain on resources. Finally, an indemnity clause should be included in the MOU, whereby liabilities for the Organization shall be covered by the financial resources managed by WHO on behalf of the partnership. In particular, the costs arising from staff grievances and appeals should be defrayed by the partnership.
5. Application of WHO rules. The fact that the secretariat of a hosted partnership forms part of the WHO Secretariat carries as a consequence that all its activities should be carried out in accordance with WHO's regulations and rules and within

