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Power to the Partners?: The politics of public-private health partnerships

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ABSTRACT *Ken Buse and Andrew Harmer review the political dimensions of global public–private health partnerships through the 'three faces of power' lens. They attempt to answer the questions: who has power; how is power exercised; and on what basis? Evidence, although scant, suggests that a northern elite wields power through its domination of governing bodies and also through a discourse which inhibits critical analysis of partnership while imbuing partnership with legitimacy and authority.*

KEYWORDS *global health; elitism; pluralism; governance; membership*

> All politics is about power. The practice of politics is often portrayed as little more than the exercise of power, and the academic subject as, in essence, the study of power. Without doubt, students of politics are students of power: they seek to know who has it, how it is used and on what basis it is exercised (Heywood, 1999: 122).

Introduction

Public–private partnerships (PPP) have become a prominent feature of our global health landscape in the past decade. As Figure 1 illustrates the number of global health PPPs has steadily increased since 1982; reaching a high-point in 2000 with 17 new partnerships.[1] Since 2000, the flurry of partnership launches has subsided, providing breathing space to reflect upon the political implications of this important mechanism of global governance.

In looking at the politics of PPPs in health we see how PPPs have introduced new actors into, and generated additional resources for, the international health arena. In doing so, PPPs have altered the relative distribution of power among organizations, between public and private sectors, and between the global North and South. PPPs have changed the policies and practices of public sector organizations, such as those of the World Health Organization (WHO), which has given rise to considerable debate and controversy (Buse and Waxman, 2001). Concerns have been raised as to whether or not such partnerships are desirable; the circumstances under which partnerships should be employed; the manner in which criteria for the selection of appropriate activities, companies and industries should be established; the best ways to structure and monitor interactions between sectors so as to avoid real and perceived conflict of interest; how

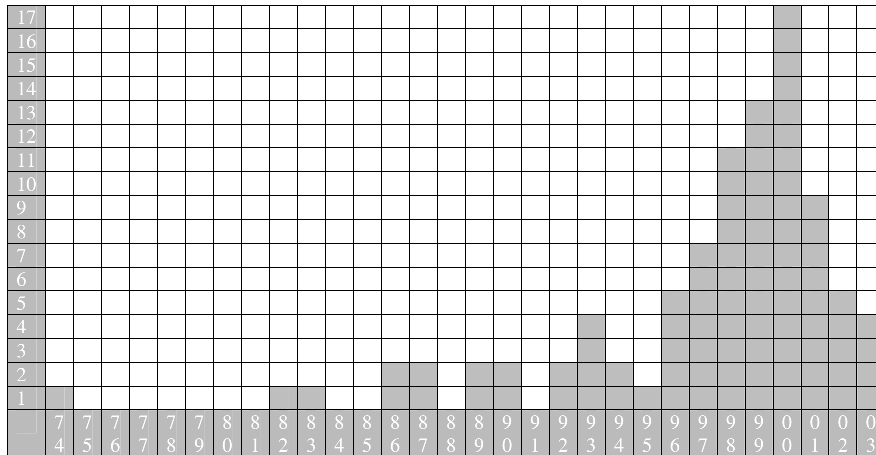

Figure 1: Number of new 'global' public–private health partnerships: 1974–2003

to coordinate the proliferation of initiatives at the global and national level; and how to integrate them into national health systems (Buse and Walt, 2000a, b; Richter, 2003).

Partnership has also created new opportunities for the private sector to exercise power and influence over domains which were once the preserve of public-sector organizations, for example, in establishing norms and standards in specific issue-areas. In other cases, new forms of global health governance are emerging, for example in the Global Fund for AIDS, malaria and tuberculosis, wherein the commercial sector is represented, thereby pluralizing decision-making bodies *and* simultaneously reshaping relations of power, authority and legitimacy. In low- and middle-income countries (LMIC), where the benefits of collaboration may be most keenly felt, fears have arisen that PPPs may exhibit characteristics which might further reinforce negative elements of aid regimes, such as the distortion of domestically set priorities and policies.

More positively, power may also be exercised through partnerships to encourage improved corporate social responsibility; to bring about better practices within public bureaucracies; to open-up decision-making to previously marginalized groups, such as civil society organizations; and more generally to promote good governance in international health. It is this potential for partnership to *transform* existing relationships, to induce conflict, to upset or reinforce the status quo, that accounts for its inherently political nature. From this perspective, the political impacts of public–private partnership on the health sector are ubiquitous and may be far reaching.

At the national level, urban studies and discourse analyses have begun to consider partnerships in terms of power (Hastings, 1999). At the global level, however, the concept of power barely features in the PPP literature. This omission is surprising because questions of power go to the heart of much that is contentious about PPP: do PPPs represent just another vehicle for powerful actors to exert their influence and satisfy their own interests; do those who govern partnerships constitute an unrepresentative and unaccountable elite who set the global health agenda as they see fit; are partnerships 'framing' global heath discourse in such a way that they shape our thoughts about, and understanding of, global health issues and, if so, how and with what implications?

Who has power?

Answers to the question 'Who wields power in partnerships?' have already begun to polarize in the literature. Analysis of the distribution of power in society traditionally makes a distinction between elitist and pluralist arguments (Walt,

1994). The literature on partnerships broadly follows this division.

Elitism

Elitist accounts, as the name suggests, focus on the role of elites in society (King and Kendall, 2004). Elitist theorists are sceptical of the depth of democracy, arguing that power is wielded by an elite core of individuals from various sectors of society. Elite theory assumptions are evident in various studies critical of health public–private partnerships. For example, Judith Richter argues that,

> High level PPP interactions . . . are in fact instruments of elite governance which advance the corporate-led neoliberal restructuring of the world (Richter, 2003: 8).

According to Richter, and other partnership critics, corporate elites dominate partnerships, and will inevitably subvert the public service of international organizations such as the UN or the WHO (Karliner, 1999; Utting, 2001; Richter, 2003). Through partnership with the commercial sector, 'the UN and its agencies have let loose a force over which they now have little control' (Richter, 2003: 7). For Richter, the solution is clear: UN agencies should abandon the public–private partnership paradigm altogether.

Pluralism

In response, pluralist accounts note the diverse range of (overlapping) interest groups seeking influence in partnerships, but contend that partnerships are neutral arrangements that do not defend the interests of any one particular actor or group. For pluralists, power is shared, no one partner dominates, and decisions are made through consensus (Held, 1996; Walt, 1994). Pluralists regard elitist criticism as exaggerated. In a recent editorial, for example, Roy Widdus argues that,

> To include one person representing the pharmaceutical industry in the 16-member Board of GAVI (the Global Alliance for Vaccines and Immunization) is unlikely to overturn the entire policy-making systems of WHO, UNICEF, the World Bank and the other members (Widdus, 2003: 235).

Corporate elite influence appears even more unlikely when one considers that the host of the GAVI secretariat (UNICEF) retains the right to veto, and each partner can ignore the Board's decisions (*ibid*).

Neo-pluralism

In -between these two positions lie studies of partnerships that may be more accurately described as neo-pluralist. Neo-pluralism acknowledges that multiple pressure groups operate within society, but argue that the agenda is, or is in danger of becoming, biased towards specific individuals and groups, often corporate players (Held, 1996). These studies remain open to the potential of partnerships but highlight the risks involved, and suggest possible ways of structuring public–private interaction so that it becomes more accountable and equitable, and less risky (Buse and Walt, 2000a, b).

The discursive construction of PPPs

The concept of partnership is *constructed* through a dominant discourse as 'natural', inevitable, and as 'win–win.' Partnerships are, therefore, considered desirable solutions to global health crises. Similarly, any negative impacts or consequences are regarded as regrettable but unavoidable: for example, the challenges of coordinating a proliferation of initiatives, or the burden placed on recipient administrations in terms of applications, monitoring and reporting. The discursive construction of 'partnership' has been so effective that criticism of partnership *per se* is almost unthinkable. Alternative modes of thinking about partnerships are, however, beginning to emerge. Richter's analysis, for example, suggests replacing the phrase public–private *partnership* with public–private *interaction*: the point being that language is not neutral, and the term 'partnership' disguises unequal power relations between public institutions and private industry, or indeed between civil society and the private sector or be-

tween North and South. In addition, innovative new partnerships such as the Drugs for Neglected Diseases Initiative (DNDi), are beginning to distance themselves from terms such as public–private to describe their interaction with private sector actors. DNDi is happy to be called a partnership, but its staff emphasize that no private-sector representative sits on its Board of governors.

It may be helpful to provide a more rigorous conceptual framework for understanding the discourse of partnerships. Constructivist analysis is rarely employed by international health scholars (Kickbusch and Buse, 2000; Kickbusch, 2003), but it can be usefully applied in this context. Klotz, for example, argues that constructivists 'seek to understand how certain ideas get taken for granted or dominate while others remain unspoken or marginalized'. Thus, constructivism should have something of value to add to the partnership debate by suggesting ways of reconceptualizing and questioning assumptions underpinning the idea of partnership. One way forward would be to apply the formulation provided by Ian Hacking in his book 'The Social Construction of What?' (Hacking, 1999). Hacking's formulation is provided in Box 1.

What Hacking's account serves to emphasize, argues Hay, 'is the stress placed by constructivists upon the contingent or open-ended nature of social and political processes and dynamics – especially those conventionally seen as fixed' (Hay, 2002: 201). Hacking's framework includes a clear normative component. However, it is possible to sound a cautionary note without dismissing PPP completely. In particular, a constructivist approach invites us to reflect upon PPP as a governance response to global health crises, and in particular to question whether or not it has been adequately compared to alternative global health strategies. In addition, it would expose many assumptions which are being made about PPP – including the absence of alternative strategies; that they are 'win–win–win' mechanisms of global governance; that they provide value-for-money in relation to public expenditure – which are not only unsubstantiated, but which are presented as justification for their continued use. Consequently, as Box 2 illustrates, the Hacking framework can be recast to raise questions about PPP.

In the context of PPP, Hacking's formulation – where X is public–private partnership – presents an alternative and exciting research strategy. Focusing attention on the interactions inherent in the relationship (rather than on an ill-defined and increasingly value-laden term such as 'partnership') reveals the opportunities, costs and risks of collaboration, *and* provides an alternative discourse which may lead to altogether different outcomes as far as collaboration is concerned.

On what basis is power exercised?

In partnerships, power may be exercised on the basis of coercion, either political or financial, but also on the basis of authority and legitimacy. In its broadest sense, authority is a form of power, although the two concepts are clearly distinct. Authority exists when a PPP has decision-making power over a particular issue-area and is regarded as exercising that power legitimately (Cutler *et al.*, 1999). In the area of neglected diseases, for exam-

Box 1. *Hacking's constructivist framework*

In the present states of affairs, X is taken for granted.
X need not have existed, or need not be as it is. X, or X as it is at present, is not determined by the nature of things; it is not inevitable.
X is quite bad as it is.
We would be much better off if X were done away with, or at least radically transformed.

Box 2. *PPP constructivist framework*

In the present state of affairs, PPP is assumed.
PPP need not be as it is. There are alternatives to PPP. PPP is not inevitable.
Alternatives to PPPs should be explored, and comparisons made, because PPPs involve significant risks as well as benefits.
PPP should take into account, as a priority, these risks.

ple, market *and* public-sector failure has meant that no drugs at all are being developed for conditions such as leishmaniasis, sleeping sickness and Chagas (M.S.F., 2001). On the one hand, the public sector lacks expertise and access to pharmaceutical industries' libraries of drug compounds. On the other hand, neglected diseases are not perceived to be profit-making investments. Through partnership with pharmaceutical companies, PPPs such as the TB Alliance and DNDi are raising the profile of neglected diseases, setting the agenda for global health interventions to resolve this crisis in R&D, and making targeted investments to catalyse drug discovery and development. The 18 GPPPH study mentioned above found that half of the sample reports the development of technical norms and standards among their activities (Buse, 2003). PPPs, therefore, enjoy an increasing degree of authority over areas of the global health sector.

Authority and, ultimately, power, requires legitimacy. Legitimacy is usually positioned between power and authority: it is 'the quality that transforms naked power into rightful authority' (Heywood, 1999: 141). PPPs have legitimacy to the extent that they are democratic, representative, and transparent (Borzel and Risse, 2003). PPPs gain legitimacy by providing a good or a welfare-enhancing intervention (output), and by reflecting the wishes and resources of those for whom the partnership is set up to help (input). The legitimacy of PPPs remains highly contentious, particularly in respect of private-sector involvement. Bruhl, for example, argues that:

> The inclusion of private actors, both for-profit and not-for-profit, enhances the problems of democratic legitimacy in international institutions rather than help to alleviate them since private actors contribute to the 'de-governmentalization' and 'commercialization' of world politics (Bruhl, 2001).

While the authority and legitimacy of PPPs may be contested, it is readily apparent that these two attributes endow PPPs with power for global health governance.

Illustrations of power being exercised in/ through PPPs

The manner in which power operates within partnerships has been subject to very little analysis. Three issues are discussed below to serve as illustrative examples of the emerging trends, as well as to provide entry points for further research. These relate to hosting arrangements, Board compositions, and membership criteria.

Hosting arrangements

Hosting arrangements may effect the distribution and exercise of power within partnerships (Buse, 2004). Partnerships may be differentiated on the basis of whether they are 'hosted' by sponsoring organization (e.g., the Global Polio Eradication Initiative (GPEI) which is hosted by WHO), or are legally independent entities, such as the Medicines for Malaria Venture (MMV). If partnerships are hosted, then a further distinction can be made between public organizations (e.g., GAVI hosted by UNICEF), NGOs (e.g., Children's Vaccine Program hosted by PATH); or private sector organizations (e.g., the Viramune Donation Program hosted by Boehringer–Ingelheim).

A study of a sample of 18 GPPHP (Buse, 2003) revealed that the 'governing bodies' of many partnerships hosted by NGO and multilateral organizations raise questions concerning the nature and meaning of 'partnership', and draw attention to the distribution of power (partnerships hosted by the commercial sector were not among the sample but are likely to raise the same issues). First, some of the partnerships, such as Coartem, the Global Alliance to Eliminate Leprosy (GAEL) and the Campaign to Eliminate Maternal and Neo-natal Tetanus (MNT) do not have governing bodies *per se* – rendering the 'sharing of decision-making' problematic. Second, a number of the initiatives, such as the Mectizan and the Malarone Donation Programs, have Technical Advisory Committees, nominally considered 'governing bodies,' which perform advisory functions but lack formal fiduciary or managerial authority. Such arrangements confer considerable power on the secretariat or host. Third, even where formal governing bodies, such as Boards, have been established, these have no legal status and often lack authority over the secretariat – the partnership secretariat and executive remain accountable up the hierarchical chain of command.

The first major external evaluation of a 'hosted' partnerships, that of RBM which is hosted by WHO, found that the 'loose' governance structure has introduced inefficiencies in decision-making and has contributed towards lack of accountability with in the Partnership,' and that the 'Secretariat is seen to be more responsive to WHO than to other Partners' (Feachem *et al.*, 2002). It may, however, be the case that the governance structure remains ill-defined so as to mask the fact that the hosting organization does not wish to relinquish control over partnership activities. An external evaluation of the Global Stop TB Partnership (Stop TB), also hosted by WHO, found 'a wide divergence of views on any hierarchical relationships among Partnership components and whether the Board has a directing or steering function within the partnership'. (Caines *et al.*, 2003). This distribution of power has significance for the perception of ownership of the partnership by partners and their consequent commitment to it.

Representation on governing bodies

Where Boards are the paramount decision-making bodies in partnerships, they provide sites of power and, at times, contestation. The composition of Boards, therefore, provides some guidance in relation to who has power. Table 1 provides data on representation in small sample of major PPPs. Although the findings may not be representative, they do suggest that the private sector is not well represented in the WHO-hosted partnerships (Roll Back Malaria (RBM), Stop TB and WHO Programme to Eliminate Sleeping Sickness (WPESS)) and that one of the independent partnerships lacks public sector representation (i.e., International Trachoma Initiative (ITI)). What is more striking is the imbalance in representation between those working for institutions based in the global North and those in the South. Some of the partnerships have no southern representation and in only one is there an even balance. Those constituencies who are represented on the governing bodies of partnerships are likely able to wield more influence over the priorities of the partnership than those which are not.

In addition, it is clear from a recent study of three neglected disease PPPs Stop TB partnership, the TB Alliance, and the DNDi (Harmer, unpublished) that the ideas which informed, and ultimately shaped the partnerships, originate from a highly unrepresentative sector of the global health community. Approximately 35 actors were identified as significant in mobilizing and providing essential support during the 'early-days' of the sample PPPs. Of these, all were from wealthy, middle-class socio-economic groupings; none were African, indeed all but one were 'white', and only four were female.

Table 1. *Representation on Governing Bodies of Select PPPs*

Partnership	Governing body	Meeting frequency	Chair	Size	Composition			Representation	
					Pub	For profit	Not profit	Non-LMIC	LMIC
GATBDD	Board	2/year	Public	11	4	4	3	10	1
GAVI	Board	2/year	Public	11	5	2	4	8	3
	Working group	4/year	?	9	5	1	3	9	0
IAVI	Board	3/year	Private	15	5	7	3	14	1
ITI	Board	2/year	NFP	7	0	3	4	7	0
MMV	Board	2/year	NFP	11	5	1	5	9	2
RBM	Board	2/year	Public	17	14	1	2	9	8
Stop TB	Coordinating board	2/year	Public	27	18	0	9	18	9
WPESS	Coordinating board	2/year	?	11	4	0	7	8	3

Membership

One of the most contested issues in relation to membership concerns whether or not to screen commercial firms for corporate social responsibility, and if so against which criteria, whether or not reporting and verification should be voluntary or mandatory and provided by independent bodies or self-reported.

The debate about membership of PPPs is contested in the health and other arenas as it is fundamentally about who has the power, authority and legitimacy to establish the standards of corporate conduct. One study of the policies of five multilateral organizations found significant differences of policy and practice in terms of the criteria adopted and the rigour of the process and in some of these organizations, particularly at the WHO, where major controversies exist at the level of the Board (Buse and Ouseph, 2002). A review of 18 GPPPHs revealed scant evidence that corporate partners to the PPPs were vetted for social corporate responsibility, financial integrity or against other negative or positive criteria prior to their selection. In many of these partnerships, the public sector had no alternative to the firm in question which might account for the lack of scrutiny (i.e., the corporate partner was in a monopoly position with respect to a product or service, which is the case for many of the access partnerships). While this may be the case, lack of competition in itself does not, reduce potential risks associated with partnering and consequently does not diminish the need for criteria and procedures for corporate selection.

Conclusions

An analysis of power within partnerships suggests that a dominant discourse has emerged constructing a paradigm of public–private collaboration that may inhibit mainstream analysis of alternatives, value-for-money for public sector investments, or the potential negative externalities that may arise at the global and national levels. Critics of partnership, often adopting a relatively simplistic approach to power, question the assumption of equal power relations in collaborative initiatives by drawing attention instead to the interactions among organizations so as to identify potential risks and risk management strategies. A similarly skeptical approach is emerging from very different quarters. The World Bank, for example, has recognized the many risks of partnership and issued detailed guidelines to enable its staff to identify the true costs of collaboration and weigh them against the benefits to the organization and its mission (World Bank, 2001). Similarly, increasingly sophisticated approaches to risk-assessment and management are emerging in the business development teams of product development partnerships (Kettler *et al.*, 2003).

Despite their political nature, the politics of partnerships have not been explicitly researched. The study of power in 'global' PPPs, in particular, deserves closer scrutiny. At the national level such study has begun in earnest, notably in the field of discourse analysis (Hastings, 1999), but also in the sub-field of Urban Studies. Students of the latter have long been aware of the possibilities of 'systemic power' in regimes (Stone, 1980; Judge *et al.*, 1995), and such analysis may usefully be applied to global PPPs.

Notes

1 The initiative on public-private partnerships for health (IPPPH), from which the data for Figure 1 is taken, has detailed information on 90 health partnerships (www.ippph.org).

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