Chapter 9
Public Private Partnerships and Government Services in Least Developed Countries: Regulatory Paradoxes

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Abstract This chapter discusses the regulatory paradoxes that emerge as public–private partnerships (PPP) that are used to supply traditional government services in least developed countries (LDCs). PPP were first developed in industrialised States to improve the quality and economic efficiency of public services in industrialised countries using market based solutions. They have become more important as governments have attempted to keep public spending under control and a general reluctance of electorates to pay higher taxes for public services. In LDCs, the issue is different: governments frequently do not have the funds to develop and maintain public services. The United Nations has endorsed the use of PPP (as a means of realising the Millennium Development Goals) that benefits the public and delivers economic development and an improvement in the quality of life. Gradually a revolution has taken place with use of private capital harnessed to deliver public services and infrastructure projects. As *Schwartz* points out, there appears an inherent conflict between the *commercial* interest underpinning PPP for social services, especially health care, and the goals of a public policy. Both goals seem irreconcilable. Yet these solutions have been transplanted to LDCs to ensure that basic social services are provided. *Schwartz* takes as a case study, the use of PPP in delivering health care services in Sierra Leone offering an analytical model to identify the concept of PPP in a developmental context of government health services in LDCs. *Schwartz* is able to offer a model which allows for the possibility of using PPPs for facilitating increased aid flows for funding a technical solution to problems encountered in health care systems in LDCs. She concludes by stating

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that whatever model is adopted LDC should retain the autonomy to choose the right regulatory mechanisms and provide the institutional capacity to meet the health challenges they face.

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'Let those who have less in life have more in law'
Ramon Magsaysay
(President of the Philippines, 1953–1957)

9.1 Introduction

The public private partnership (PPP) doctrine was conceived out of the need to ensure economic efficiency and to improve the quality of public services in developed countries. The underlying rationale is that efficiency in the management of public services will be enhanced through collaboration between public and private entities including, some interaction between their distinct legal and regulatory framework and using market-based solutions. The doctrine has its roots in the policy of liberalisation of services markets which was championed mainly by the developed countries through the global trading system and anchored by the influence of private transnational corporations (TNCs) over the economic activities and relations of states.

The TNC according to Cutler, acquire a specific structure of authority and hegemony which couples with the dominance of liberalism to entrench 'global political authority'; and such authority is made effective due to the strategic location of the private TNC at the nexus between economics and politics, private

and public activities, and local and global political economies.[1] This 'global political authority' deeply implicates the TNC in undermining the role of the state especially in its effort to direct the process of development through distinctions of the public and private divide. The wave of the British experiment with large-scale privatisation programmes in the early 1980s altered the respective roles of the public and private sector worldwide as it encouraged private firms in productive activities that were traditionally owned and managed by the state.[2]

In the special case of the LDCs,[3] however, privatisation evolved mainly through pressure from the international donor agencies (where aid has been conditional on privatisation) and from domestic capital market interests at the expense of transparency.[4] Infrastructure development and extractive industries were initial targets for private sector involvement.

Today the PPP concept re-brands the privatisation agenda in an aggressive bid to ensure predominant private sector participation especially of the private TNC in government services primarily to entrench the policy of market liberalisation and to complement the trend of economic globalisation. We are warned that *laizer-faire* liberalism is not the spontaneous automatic expression of economic facts; but a political programme of deliberate policy designed to change the state's leading personnel and the economic programme of the state itself.[5] This is true in the case of the role of the State, in the health sector.

Health and social services have long been considered the direct responsibility of a country's government. In many countries medical services are operated on a non-market basis and are considered by many to be a national public good and therefore not appropriate for commercialisation. Current state practice, however, shows that numerous countries now employ institutional approaches and regulatory regimes that structure health care with stronger market orientation thus widening the space for increased private participation.[6] Yet the term PPP bears no certain legal definition. It is usually used in reference to the legal regime of a given partnership, the institutional framework governing PPP operations and the regulatory conditions that border partnership interests. The prevailing policy objectives driving PPP include the creation of an enabling business environment, the promotion of innovation, competition, and social regulation, and to ensure

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[1] Cutler 1999, p. 66.

[2] United Nations ST (1997) p. 3.

[3] Reference to LDC depicts as a special group of states characterised by a low income level and structural impediments to growth, and requiring special measures for dealing with those problems. This designation is based on a simple set of criteria (per capita gross domestic product (GDP), share of manufacturing in GDP and adult literacy; see Handbook on the Least Developed Country Category 2008 (accessed July 2009).

[4] United Nations ST (1997) p. 5.

[5] Supra n. 2.

[6] International Trade Centre (ITC) Business Briefing Trade Policy: WTO Services—'Service Sector: Health related and Social Services' (ITC Business Briefing) available at: http://www.intracen.org/btp/wtn/newsletters/2010/services12.htm (last accessed 02/04/10).

international cooperation on these; work force development and risk-sharing with the private sector (through venture capital investment) are recent additions.[7] Invariably an effective regulatory framework and substantial state action is required to implement these objectives. Within this market centred rationale, embedded legal uncertainty and regulatory conundrum, PPP is widely promoted as a development tool that could ensure basic health and social services in LDCs.

But the state of most LDC health sectors including Sierra Leone is deplorable. Inadequate government health infrastructure, poor primary health care service conditions, the prevalence of diseases, unemployment, and poverty paint a grim picture for competitive marketing of LDC health services. More particularly, sub-Saharan Africa is furthest behind on almost all of the health related Millennium Development Goals (MDGs) and is losing ground in obtaining more funds for disease prevention, access to affordable drugs for treatment, and increased aid to build functioning public health systems to administer these.[8] It is in recognition of this grim peculiarity of LDC health sector challenges that this article advocates and scopes a *developmental context* of health services delivery for LDCs. The context represents primarily a pursuit of policy objective for the promotion of affordable, accessible, and universal health care services, as a public purpose for which the government is to provide, facilitate, and regulate in the interest of its people.

Under the principles of the UNICEF/WHO Alma-Ata Declaration, the provision of such health care should be 'at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.'[9] Over the years however, the LDC governments have relied on official financial flows including loans, grants, export credits, and publicly guaranteed debt to fulfil this public purpose. But the trend of decline in the official flows to LDC and the substantial increase in unofficial 'private for-profit' finance and other private cross-border giving noted by Harford et al. contorts the performance of this function.[10]

Ultimately, at the turn of the century, concerns over the high rate of communicable and deadly diseases and the need to ensure global health security paved the way for a reconditioning of the LDC health objectives as a global agenda to be addressed in a '*global partnership*'. Under this partnership, the global community' with the cooperation of pharmaceutical companies assume responsibility

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[7] See Trubek 2009, p. 31.

[8] UNICEF 2008 (accessed 8/05/09); also The International Development Research Centre 'Privatization, Liberalization and GATS' (The IDRC) available at http://www.idrc.ca/en/ev-67858-201-1-DO_TOPIC.html (last accessed 06/03/10) 9.

[9] UNICEF/WHO Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September (1978) para 6 (Alma Declaration).

[10] Harford et al. 2005, pp. 1–2; unofficial flows include foreign direct investment, migrant workers' remittances, portfolio equity flows, grants from NGOs, and loans without a sovereign guarantee. Other giving includes foundations, corporations, religious groups, and membership-based NGOs.

particularly for reducing child mortality, improving maternal health, combating HIV/Aids, malaria, and other diseases.[11] Action on the explicit and specific commitments to establish a global fund on AIDS, TB, and malaria (on an initial pledge $1.3 billion) evidences in the GFATM.[12] This globalisation of partnership introduces the doctrine of PPP in LDC health delivery systems in a transformational way that blurs the distinction between the traditional economic orientated PPP and the developmental context of PPP in LDCs.

This chapter discusses the doctrine of PPP and its application to LDCs health delivery systems especially through the lens of Sierra Leone's health sector. It examines different types of PPP arrangements under broad categories namely: international trade and economic partnerships, global health partnerships, development PPP, and domestic health initiatives to illustrate the practice of respective health PPP. It examines the regulatory problems engendered by complex system of PPP arrangements and questions the appropriateness of marketing 'public–private for profit partnerships' as a development mechanism for delivery of health services in poor countries. It proposes a *developmental context* of PPP and recommends a pro-active role for LDC governments in regulating development partnerships as vital for achieving their public health goals. The following section, presents an analyses of the various permutations of PPP in aid of extrapolating if any, a *developmental context* of health services applicable to LDCs.

9.1.1 The Doctrine of Public–Private Partnership

The United Kingdom Private Finance Initiative of the 1990s attempted a systemic programme for PPP that was focussed on limiting public expenditure. Much later, emphasis was placed on public purchases of quality services and risk allocation. Under EU law, PPP enjoys prominence through concepts of SGI and SGEI,[13] and shaped by EU policy on competitive tendering of public works and services. Yet the term remains undefined and there is no specific system governing PPP.[14]

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[11] UN Millennium Development Goals (MDGs) available at http://www.un.org/millenniumgoals/goals.html# (last accessed 07/08/08).

[12] The IDRC, supra n. 8 at 9 Note that the generic commitments on a key role for strong national health systems in the delivery of effective prevention, treatment and care, and in improving access to essential health services and commodities without discrimination continues on the low end of the total budget of ODA support for health.

[13] A SGI is a non-economic service which is not traded on the market and in which users and their requirements are the main focus of public action) and SGEI is an economic service that operates in a market environment). EC Commission, *Services of general interest in Europe* (2001/C 17/04) EN *OJ* (2001) C 17/7.

[14] EC Initiative on Public Private Partnerships and Community Law on Public Procurement and Concessions. http://ec.europa.eu/internal_market/publicprocurement/ppp_en.htm (EC PPP Initiative) (accessed 08/04/09).

In general, the term refers to forms of cooperation between public authorities and the *world of business* which aim to ensure the funding, construction, renovation, management or maintenance of an infrastructure, or the provision of a service.[15] According to the then Commissioner for Internal Market and Services, it is still unclear how the existing 'patchwork quilt' of rules should apply to PPP.[16] He also notes the difficulty in developing a coherent framework that provides the public and the private side with legal certainty and to facilitate institutional framework within which PPP can work most efficiently.[17]

The UN Study Group Report defines PPP as implying 'a common understanding of shared goals, a willingness to repartition responsibilities for their achievement, a continuing public–private dialogue on what needs to be done to promote their realisation, and a supportive policy and institutional framework.'[18] According to the United States National Council for PPP, the concept refers to contractual relations between a public agency and a private sector entity for the purpose of sharing skills, assets, risks, and rewards potential of each sector in the delivery of service or facility for the use of the general public.[19] From the United States perspective, PPP does not represent 'corporate philanthropy' or 'charity work' to help poor nations but forms a cooperative alliance that can *benefit business* and the society in which the business operates.[20]

The African Union (AU) and its New Partnership for African Development (NEPAD) agency, view PPP as a means to 'achieving economic transformation in Africa by working closely together with the private sector in utilising respective core competencies to form synergies and achieve results collectively.'[21] PPP is also having a role in increasing public financing for the provision of basic infrastructure, for example, roads, energy, and water supplies and advancing the African Agenda under WTO and EPAs.

In other forums, however, a social dimension of PPP is shaping what is described as 'public-social-private partnerships' (PSPP). This concept derives from the inapplicability of business and profit led PPP model to fulfil public aims such as the common good and welfare.[22] PSPP covers, cooperation models

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[15] Ibid. [emphasis added].

[16] McCreevy 2005 (accessed 08/04/09).

[17] Ibid.

[18] United Nations ST (1997) p. 2.

[19] National Council for Public Private Partnerships: 'How Partners Work' http://www.ncppp.org/howpart/index.shtml# (NC/PPP) (last accessed 06/04/09).

[20] Green 2008 (last accessed 06/04/09).

[21] Declaration The African Private Sector Forum: 22–23 January (2008) Addis Ababa, Ethiopia p.4; also NEPAD Business Group: AU pursues stronger public–private sector partnership June (2004) available at http://www.commit4africa.org/declaration/assembly-african-union-12th-ordinary-session-addis-ababa (last accessed 06/04/09).

[22] 'Public/social/private partnerships are methods of co-operation between private and government bodies' available at: http://www.answers.com/topic/public-social-private-partnership#From_PPP_to_PSPP (PSPP) (accessed 28/05/09).

between participants that are not only agencies of the state and private enterprises (as in PPP), but also social enterprises and social economic organisations.[23] The goal of PSPP financing tool is the servicing of social protection and supporting interests and activities for the improvement of opportunities for disadvantaged people or groups.[24] PSPP models should only be supported by the state in cases where they serve the long-term social needs of disadvantaged members of society. 'This responsibility belongs to the state and the state only.'[25]

The forgoing permutations of PPP are split on emphasis between business orientation of the PP concept and the developmental. The UN and PSPP descriptions represent a more cohesive framework and approach to PPP from which the *developmental context* of LDC health services could construct. The commonality of partnership goals, the recognition of other social private partners, the strategic partitioning of health responsibilities by the state, and a supportive institutional framework that allows for policy considerations of the state and continuing dialogue on implementation of social goals, frames the *developmental context* of health services in LDCs, that is the promotion of affordable, accessible, and universal health care services to citizens as a public purpose which the government is to provide, facilitate, and regulate.

The following section will illustrate the various partnership models that can be derived from health and social services in order to present a context of practical application of the various permutations of the PPP doctrine discussed above.

9.1.2 Partnering Models for Health Facility and Services

There are several models of partnering mechanisms for engaging private sector participation especially in public hospitals, health centres or clinics. The discernible models include facility arrangements involving construction, ownership type, management, operation and maintenance, and other financing agreements. These are notably:

(a) *Build-Own-Operate* (*BOO*)—private firm builds, owns, and operates a public hospital;
(b) *Build-Operate-Transfer* (*BOT* or *BTO*)—a private partner builds and operates the hospital facility (contract or franchise) and transfers it to the public agency after a period of time;
(c) *Buy-Build-Operate* (*BBO*) *or Lease-Develop-Operate* (*LDO*)—a form of asset sale (or lease) in which a private operator invests capital to rehabilitate or expand existing facility and operates it under contract with the public agency;

[23] Ibid.
[24] Ibid.
[25] Ibid.

(d) *Design-Build-Maintain* (*DBM*)—private partner designs, constructs, and has responsibility for maintenance of the facility; but ownership of asset remains with the public agency;
(e) *Purchase-Leaseback*—the private firm finances and builds a new public hospital then leases it back to the government;
(f) *Contract Services for Operations, Maintenance and/or Management*—transactions involving private management of a public hospital, out sourcing support services (clinical, non-clinical, and specialised), procurement of labour, medicine, equipment; and technical expertise. Also *collocation agreements* in which a private wing is located within or beside a public hospital;
(g) *Tax-Exempt Lease*—a public partner finances capital assets or facilities by borrowing funds from a private investor or financial institution. The private partner generally acquires title to the asset, but then transfers it to the public partner;
(h) *Developer Finance*—the private party finances the construction or expansion of a public facility in exchange for the right to build a profitable facility at the site and receive future income from user fees (residential homes, commercial stores, or industrial);
(i) *Turnkey Model*—the private developer commits to build the facility for a fixed price and absorbs the construction risk of meeting that price commitment;
(j) *Free entry model*—where qualified private providers are allowed to freely enter and exit the health care market without establishing a contractual relationship with the government. Other applicable regulatory instruments for ensuring safety and minimum quality of care include: licensing, certification, and accreditation. Government might also use financial and other incentives (taxes, subsidies, and training opportunities) to influence the behaviour of private providers.[26]
(k) *'Institutionalised PPPs'*—arrangements 'outsourcing of public tasks, which involves the creation of public service undertakings held jointly by both a public and private partner.'[27]

Traditionally, health and social services are generally considered to be a national public good for which a country's government must have direct responsibility to provide and operate on a non-market basis. In other cases, these services are delivered by both private and public suppliers, often done on behalf of the government and not on a commercial basis per se.[28] This element of non-commercialisation or marketability of such services is an attribute of the *developmental context* of health services that is applicable to LDCs and which could

[26] See generally, Taylor and Blair 2002; Marek et al. 2003; NC/PPP supra n. 19.
[27] McCreevy 2005.
[28] ITC Business Briefing, supra n. 6.

potentially ensure accessibility of a government's citizens to essential health services without discrimination.

The permutations of PPP doctrine which emphasise the business environment over the social element including a focus on cost and economic efficiency, explains why regulatory regimes in numerous countries have been moving in the direction of stronger market orientation.[29] This trend opens space for increased private participation of domestic as well as foreign providers in public health care delivery through one or more of the partnering models outlined above. The International trade Centre identifies three types of institutional approaches to how health care is structured along market oriented partnerships especially in OECD countries and in other economically advanced developing countries.[30] These are:

- *Reimbursement systems*: here the patient pays for the service supply (retroactively) and is then reimbursed by his insurer or the insurer makes the payment directly[31];
- *Contract systems*: here, a compulsory insurance is normally provided by a limited number of public or non-profit agencies and an agreement establishes the terms and conditions of cooperation between consumers and the specified health care providers[32];
- *Integrated health systems*: Here medical personnel and other health care spending are normally funded and controlled by one single institution which usually is the government.

The PPP partnering models for engaging private sector participation in public oriented health systems (be it in the form of facility, management or financing agreements), are clearly representative of the EU, US and AU permutations of PPP. These models generally tend to emphasis the business environment of health service transactions over the social element. They advocate cooperation only between public agencies and private enterprises with a focus on infrastructure, cost, and efficiency. This dimension undermines the UN and PSPP view of PPP, which as observed earlier, represent a more cohesive framework and approach to PPP from which the developmental context of LDC health services could construct. The developmental context recognises the role of other social private partners, the duty of the state to strategically partition health responsibilities, and the importance of having a supportive institutional framework that would allow for policy considerations of the state and continuing dialogue on implementation of health and social goals. This dimension has the potential to promote affordable,

[29] Ibid.

[30] Ibid.

[31] This system caters for multiple providers usually private insurance companies thus providing the patient a wide scope for selecting the preferred health care providers and the service supply.

[32] Under contract systems hospitals are usually funded on the basis of per diem rates or fees per case or service and may be subject to budget caps. People tend to be invariably restricted to a pre-selected range of hospitals, while others allow for treatment by additional providers similar to the reimbursement system.

accessible and universal health care services to citizens as a public purpose for which the government is to provide, facilitate and regulate.

9.1.3 Partnering Models and Sierra Leone's Primary Health Care Facility

How do the various partnering models apply to Sierra Leone's primary health care facility services (PHC/FS)? First there is an estimated total number of eight hundred and ninety-eight PHC/FS including hospitals, community health clinics (CHC), and maternal child health clinics (MCHC) and posts scattered around twelve districts in the provinces and the Western Area and Urban including Freetown, the capital.[33] Each provincial district has at least one (not more than two) government hospital in terms of ownership and management. There are twelve private hospitals in six districts which operate independent from government; eight of these are mission hospitals and four are industrial hospitals including the diamond mining company facility.[34]

The Western Area has two government hospitals while Western Urban (Freetown) has ten government hospitals and thirty-nine private and industrial hospitals. Most of the private facilities are owned (by medical practitioners) and managed privately. Three of the ten government facilities are in some form of PPP arrangement. For example, the Choithrams Memorial Hospital represents a Model (d) *Design-Build-Maintain* (*DBM*) arrangement—Choithrams designed and constructed the facility and has responsibility for the maintenance of the facility but ownership of asset remains with the public agency. There are foreign Indian doctors operating in the Choithrams hospital. Also, a variant of Model (f)—*Collocation Agreements* exist between the GOSL, the UNAMSIL Mission (a UN agency) and the hospital management. The GOSL is currently negotiating another 'collocation agreement' between Choithrams hospital and the Italian NGO Clinic 'Emergency Life Support for War Victims'.[35]

There is future potential for adapting a blend of PPP health facility Models (c), (f) and (g) under terms of a recent World Bank IDA Grant. The grant is for the restoration of the essential functions of health care delivery system and for strengthening both public and private health sector capacities, in order to improve the efficiency of

[33] Two hundred and fourteen of these facilities, (mainly CHC and MCHC) are not functioning and an estimated 100 need rehabilitation.

[34] Directorate of PHC, *The Primary Health Care Hand Book Policy* Ministry of Health and Sanitation, (MOH/SL): Freetown, SL, May 2007 (PHC Handbook).

[35] See MOHS/SL *A Handbook of Health NGOs, Donors and other Partners in Sierra Leone*, MOHS Youyi Building Freetown, Sierra Leone January (2008). (Donor Handbook) Also, Fofana Ibrahim L, Liaison Officer for Donor Relations, MOHS/SL—Comments from Interview held on 23/04/09 at the MOHS Youyi Building Freetown, Sierra Leone.

the health sector.[36] The provisions include, inter alia, rehabilitation of selected hospitals and health centres and acquisition of clinical and related services, the procurement of goods and works through competitive bidding, including through '*direct contracting and procurement from United Nations Agencies*'.[37] Other policy conditions attached to the grant requires the GOSL to enhance private sector participation in the delivery of quality health services through, inter alia, 'contracting out' services and provision of incentives to potential private sector entities.

In the *developmental context* of LDC health services, appropriate health infrastructure and effective facility management is vital in ensuring affordable and universal access for all social groups. But how can one reconcile the concept of 'economic efficiency' with 'equity' in PPP? How do the various PPP health facility models appreciate the concept of universal access and affordability in a poor country lacking national health insurance or mandatory employer insurance schemes? In fact a UN report cautions that the economic rebalancing that is necessary under transition to PPP can undermine the basic political and economic goal of most governments: that is, the provision of basic needs to the lowest income Groups.[38] The transition could also place new resource and skills demands on government agencies and risk conflict in the application of rules.

What the discourse suggests is that the inception of health facility PPP models in LDCs contemplates fundamental complexities and critical policy issues. In particular how to ensure universal and affordable health care to an uninsured population in a *public–private-for-profit-partnership*. What will be the cost to government employing incentive systems, exclusivity privileges, and tax exemptions to facilitate such access? What will be the effect on competition and the private sector enhancement on already struggling public health services? In my view, serious consideration should be given to developing a national health insurance scheme. In the interim however, LDC governments would need to assess the appropriateness of legal instrument, regulatory mechanism, and institutional framework in their collaboration with private health services suppliers.

9.2 International Cooperation: Trade and Other Economic Arrangements

The role and nature of PPP in international cooperation of states for pursuit of LDC health objectives is quite complex. First, it does not immediately translate the private component of PPP. Second, there is a dichotomy between interstate

[36] Health Sector Reconstruction And Development Project: Grant Number H289—SL Financing Agreement (Amending And Restating Development Grant Agreement) Between Republic Of Sierra Leone And International Development Association Dated July 11, 2007 (World Bank/SL HSRD Project (2007).

[37] Ibid. [emphasis added].

[38] United Nations ST (1997) p. 4.

cooperation in multilateral and regional institutional settings on the one hand and in bilateral context. Then there is the component of global cooperation on health issues which is more inclusive, encouraging variety of public–private entities to collaborate on the achievement of universal health goals or on issues within respective mandates at domestic level. Also, the legal arrangement that may govern each strand is not always certain, and is largely policy driven or based on broadly stated principles or other 'soft law'. The following section discusses selected cooperation models under PPP in relation to the WTO rules, particularly the GATS and TRIPS agreements on the one hand and that of international and global partnerships.

9.2.1 PPP and WTO Rules

Cooperation on international trade is important for health service delivery in LDCs. For example, most LDC WTO member governments lack manufacturing capacity of essential medical products. The context of globalisation of partnerships would require the setting up of foreign companies or organisation across borders for the supply of health service either on a commercial or non-commercial basis. Similarly, WTO LDC members would need to access medical technology to facilitate better health conditions for their peoples. The WTO General Agreement for Trade in Services (GATS) and the Agreement on Trade Related Intellectual Property Rights (TRIPS) can ensure these transactions within prescribed rules, general principles, and special policy considerations under the WTO framework. This section examines the context of PPP in the relevant WTO agreements especially its role in enhancing health development goals as a governmental purpose in LDCs.

9.2.1.1 The Services Agreement (GATS)

The GATS agreement constitutes the legal framework through which WTO Members could progressively liberalise trade in services including health-related services. The prevailing perception is that the GATS is primarily a vehicle for the expansion of business opportunities for TNC, which 'locks in' existing service privatisation and liberalisation policies in order to secure and entrench pro-competitive policies in areas that have been autonomously liberalised.[39] The key concern is that GATS will unavoidably lead to increased privatisation of essential public services as health care, although the joint WHO and WTO publication assures us that '… all the WTO agreements explicitly allow governments to take measures to restrict trade in pursuing national health policy objective.'[40]

[39] The IDRC supra n. 8.

[40] ITC Business Briefing supra n. 6.

It is argued that the liberalisation of health services could facilitate the introduction of new private resources that could support the public health system in developing countries and provide new and more efficient management techniques including for medical professionals.[41] David Woodward maintains that the distinctive features of the market for health services, particularly in developing countries, means that the 'benefits of trade' argument is not applicable and that GATS policy seriously constrains health policy.[42] Concerns remain over the fact that private investments in health services would emphasise those services for which a market exists and therefore likely to be concentrated in services for the affluent.[43] Such investments which focus on increased income uneasily aligns with health services where the goal is not increased income but equitable access to quality services, including by those who may not be able to purchase traded services. These concerns warrant an examination of the nature of GATS influence on PPP and the impact on LDC developmental context of health services.

Health services applicable under the GATS agreement are classified under two main categories namely[44]:

- *hospital, social, and other health services* (for example, health services delivered under the supervision of doctors, residential health facilities, and ambulance services) and
- *professional services* (for example, medical, dental and veterinary services, and the services provided by nurses, midwives etc.)

Article 19(2) GATS explicitly provides that liberalisation must take place with due respect for national policy objectives and the level of development of individual WTO members. The extent to which the health sector of an individual country is liberalised, allowing for increased involvement of the private sector in public health services in particular, will depend on the nature of commitments made in its schedule defining the level of trading rights that are guaranteed under the GATS. Pursuant to Articles 15 and 16 of the Agreement, commitments are made in terms of 'market access' (opening the market to foreign providers) and 'national treatment' (treating foreign providers the same as domestic providers). These commitments could be effected with respect to any combination of the four modes of 'supply of services'[45] namely cross-border supply, consumption abroad, commercial presence and presence of natural persons[46]:

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[41] The IDRC supra n. 8.

[42] Woodward 2005, pp. 511–534.

[43] The IDRC supra n. 8.

[44] See 'Health and Social Services' available at: http://www.wto.org/english/tratop_e/serv_e/health_social_e/health_social_e.htm (last accessed 04/03/09).

[45] This includes the production, distribution, marketing, sale and delivery of a service: Article 28.

[46] GATS Article 2 (a)–(d).

- The *cross-border supply* mode involves the delivery of health services from the territory of one Member State in the territory of another Member State[47]: (for example, include internet consultation, 'tele-health' services, diagnosis, treatment medical claims processing, medical records transcription services, shipment of laboratory samples, and medical education);
- The *consumption abroad* mode, known in health parlance as 'health or medical tourism' caters for incidents when patients seek treatment abroad especially when such treatment may be unavailable in the home country or where it is more affordable in another country (for example, patient medical care or to undergo surgery);
- The *commercial presence* mode governs the supply of health services in one Member State, through investment by foreigners (natural persons, companies or a firm) in the territory of another Member State. Such investment could be for the provision of health insurance, establishment of private hospitals, clinics, treatment centres other health operations (like technical assistants), or management contracts for such facilities, whether they are public, or private;
- The *presence of natural persons* mode covers the temporary movement of health professionals from one country to another. This category will include medical specialists (doctors, nurses, or dentists) moving to a foreign country on a temporary basis to provide expertise to a hospital or medical services provider.[48]

The GATS agreement allows WTO Members to choose which service sectors to open up to trade and foreign competition and by which specific mode of service supply. Under the provisions of Article 27(a), the GATS will apply where member governments, institute measures[49] that 'affect' trade in health services relating to any of the four supply modes explained above.[50] Second, pursuant to Article I: 3(b) and (c), GATS will apply where such measures relate to the provision of health and social services that are not in the 'exercise of government authority' because they are supplied on commercial and competitive basis. Similarly, the rules on specific commitment (Articles 2, 16 and 17) are not applicable to measures governing procurement by governmental agencies of services for a governmental purposes, provided that such services or their supply are not purchased

[47] In other words suppliers and consumers are located in different countries.

[48] Note that under the Annex on Movement of Natural Persons, Members remain free to apply measures regarding citizenship, residence or employment on a permanent basis.

[49] These could be in the form of 'a law, regulation, rule, procedure, decision, administrative action, or any other form.'

[50] GATS Article 28: 'measures by Members affecting trade in services' include measures in respect of: (i) the purchase, payment or use of a service; (ii) the access to and use of, in connection with the supply of a service, services which are required by those Members to be offered to the public generally; (iii) the presence, including commercial presence, of persons of a Member for the supply of a service in the territory of another Member. Other measures or policies that may not be affected by specific commitments include non-discriminatory domestic regulations (for example, standards, licensing requirements); non- discriminatory subsidies; export-related measures (for example, promotion and restriction) and visa requirements.

with a view for commercial resale or with a view to use in the supply of services for commercial sale.[51] Accordingly, the GATS contain a government 'carve out' that seek to ensure governments' ability to set and implement public health measures or policies (including through PPP arrangement) that are non-commercial or non-competitive in nature.

The GATS recognises that increasing participation of developing countries in world trade shall be facilitated through negotiated specific commitments for the strengthening of their domestic services capacity and its efficiency, and competitiveness, inter alia, through access to technology on a commercial basis. This consideration accentuates the market oriented dimension of health services that potentially overrides the government 'carve out' for provision of public health services. However, the GATS recognises the serious difficulty facing LDC in accepting negotiated, specific commitments in view of their special economic situation and their development, trade and financial needs.[52]

9.2.1.2 The GATS, PPP Concept and LDC Health Services

What the above analysis so far suggests in the context of the applicability of the PPP concept and related partnering models is that the GATS classification of supply modes could basically cover PPP facility, management and financial services models outlined above including the institutional approaches operative in the models of reimbursement, contracts and integrated systems. PPP under the GATS Agreement would apply where health and social services are provided by both private and public suppliers through various legal forms of collaborative partnerships. In other words, the private foreign supplier could be sole provider of health services on behalf of the government (monopolies or exclusive suppliers) either on a commercial or none commercial basis. However the requirement of non-commercialisation (non-profitability) and non-competitiveness is the fundamental *caveat* that must inform any PPP arrangement for supply of health service especially where the purpose is to facilitate the *developmental context* of health services.

Problems could arise as to the classification of social services that could be provided by private organisations on behalf of government on a part commercial and part aid funded/charity basis which may be necessary for ensuring the developmental context of health services especially in LDC. In other words, since most countries allow some commercial or competitive provision of virtually all public services the caveat may not adequately shield government measures for

[51] See GATS Article 13(1). Other measures or policies not affected by specific commitments include non-discriminatory domestic regulations (for example, standards and licensing requirements); non- discriminatory subsidies; export-related measures (for example, promotion and restriction); and visa requirements.

[52] GATS Article 4(1)(a) and (3).

public health from a trade challenge. In fact it becomes difficult in particular cases to determine what is excluded from the category of social services.

Notwithstanding the forgoing anomaly, LDC members could be able to form PPP for the supply of Health services through the various supply modes such as foreign medical professionals, patients, technical assistants, or the foreign ownership or management of hospitals, clinics or office within their territory or of WTO Member States.[53] Over half a dozen sub-Saharan African countries have committed to full liberalisation of several modes of medical and dental services, including provisions for private foreign investment, with only one such country having made any GATS commitments involving specialised medical services.[54] It could be possible under GATS for such LDC members to institute health services PPP within the commercial and market orientated framework. But they may need to circumvent the obligation requiring them to give like foreign health services or service providers in their country equal treatment as that afforded to the foreign PPP service providers in their countries; or to make available to other foreign health service providers the same privileges enjoyed by domestic health service suppliers.[55]

LDC member governments may avoid this obligation by stipulating conditions and limitations they wish to maintain in the sector to regulate participation within their PPP policy preference.[56] They would also be required to publish promptly all measures taken in respect of the PPP arrangement pertaining to or affecting the operation of the GATS and should notify the Council for Trade in Services of all related legal or regulatory changes.[57] More importantly, LDC members may even choose not to schedule their health sector at all and so operate their PPPs outside WTO rules[58]; or they could invoke the special LDC 'needs' consideration principle, or the GATS policy exceptions for protection of human health especially given the prevalence of diseases in most LDC.[59]

It may be that LDC members have undertaken the WTO-type commitments in other economic partnership arrangements governed by different regimes. Even in this case, as noted by Adlung and Carzaniga, GATS Article 5:3 offers several elements of flexibility to developing countries participating in EIAs.[60] For instance, the prohibition of new or more discriminatory measures is to be applied

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[53] See GATS Article 1:2(c); Article 28(d) and Article 28(m)(ii); also, see generally, Smith et al. 2008, pp. 437–446; Adlung 2005, p. 11.

[54] Note that these countries have made these GATS commitments with fewer limitations than those defined by the already well-developed EC 12 members. See generally GATS Schedules; and The IDRC, supra n. 8, pp. 7–8.

[55] GATS Article 2.1; (The Non-discrimination—MFN Principle); Article 16 and 17 (Market Access and National treatment specific obligations as inscribed in members' Schedules).

[56] GATS Article 20.

[57] GATS Article 3 (Transparency obligation).

[58] GATS Article 5 (Economic integration).

[59] GATS Preamble (paras 3–6) and also Article 4 and Article 14.

[60] Adlung and Carzaniga 2009, p. 8.

in accordance with the level of development of the countries concerned both overall and in individual sectors.[61] At another level, LDC members may be able to take policy measures to form a non-commercial and non-competitive *developmental context* PPP with a foreign health services supplier for the purpose of providing or facilitating universal and affordable health services to their citizens. Such arrangement will be exempt from the scope of the GATS entirely, on the basis that the particular health service is supplied in the exercise of 'governmental authority' and is 'supplied neither on a commercial basis, nor in competition with one or more service suppliers.'[62] Invariably, as Adlung and Mattoo clearly suggest, 'there are virtually no policy regimes that would be GATS- inconsistent per se, or at least, that could not be accommodated under the exceptional provisions.'[63]

Sierra Leone has market access limitations in relation to all sectors in its schedules including Health services in terms of the 'commercial presence' mode of service supply. It requires that foreign service providers incorporate or establish the business locally in accordance with the relevant provisions of Sierra Leone laws and, where applicable, regulations particularly with respect to land and building acquisition, lease or rental. It maintains no market access and national treatment limitation over its health sectors other than (in context of professional services) that commercial presence must take the form of partnership.[64] The foreign ventures shall have to be competitive and registered institutions in their own countries. This limitation requiring competitive foreign ventures (albeit in own countries) could potentially affect the non-commercial and non-competitive *developmental context* of PPP that could be possible. Such discrepancies highlight PPP regulatory paradoxes. It also lends validity to scholars who question whether measures that may uneasily sit between public and private law obligations and having a 'mixed regulatory/commercial character' are measures for the GATS.[65]

The TRIPS Agreement

The TRIPS Agreement regulates intellectual property rights (IPR) protection within the WTO free trade agenda. It recognises the *private* nature of IPR on the one hand, and the *public* element underlying policy objectives of national IPR systems especially the developmental and technological. The Agreement aims

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[61] Ibid.

[62] Articles 1:3(b) and (c). For scholarly literature on the definition of 'government service', including perspectives on whether GATS impinge on the ability of government to provide vital social services and possible policy choices open to WTO members in the area of services regulation see Krajewski 2003; Adlung 2005; Smith et al. 2008; Adlung and Carzaniga 2009; Adlung and Carzaniga 2001, 352 et seq.; David 2004.

[63] Adlung and Mattoo 2008; Adlung 2005; Adlung and Carzaniga 2009, p. 8.

[64] WTO Schedule of Commitments.

[65] Lang 2004, p. 813.

to address the difficulty in finding harmonised standards for protection and enforcement of IPRs and to ensure a balance between private rights and public obligations. As a basic principle, WTO TRIPS seeks to ameliorate the impact of enhanced protection of IPR on social and economic welfare by allowing its members to adopt measures necessary to protect public health and nutrition and to promote the public interest in sectors of vital importance to their socio-economic and technological development.[66]

Prior to the TRIPS agreement, the issue of intellectual property did not affect the manner in which developing countries and LDC could obtain essential medicines (on or off patents) since the process depended much on their procurement methods, local production capabilities, public health policies and general financial resources.[67] But the TRIPS regime by Article 28 provides exclusive rights for the inventor as an incentive for innovation with limited exceptions for consumers to use such inventions. For many LDC however, innovation gains could never fully compensate for the intellectual property rights monopoly-related losses[68] (including harm to global access to legally, affordable essential medicines). However, the TRIPS Agreement and other initiatives taken by the WTO members for the protection of public health provide some flexible mechanisms by which developing countries and LDCs could access essential pharmaceutical products easier.

One such mechanism is Article 6 which allows WTO Members to set own policies concerning the 'exhaustion' of IPR and also to create their parallel imports system within the chosen policy.[69] International exhaustion occurs when national law allows importation of an IPR protected product without the authorisation of the patent holder, after that product has been legally sold more cheaply in a foreign market.[70] This mechanism allows developing countries to search the global market place for pharmaceutical products that are priced lower than that available in the home market. In this regard, whether or not LDCs have the capability to manufacture medicines they could access essential drugs by parallel importation.

Another provision in aid of LDC access to pharmaceutical products under the TRIPS Agreement is Article 30 which allows for exception to the exclusive right of patent-holders 'provided that such exceptions do not unreasonably conflict with a normal exploitation of the patent and do not unreasonably prejudice the legitimate interests of the patent owner, taking account of the legitimate interests of third parties.' This provision encounters certain difficulties in that the conditions do not set clear boundaries on what are to be considered permissible exceptions.

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[66] TRIPS Articles 7 and 8.

[67] Abbott and Reichman 2007, p. 927.

[68] Messerlin 2005, pp. 1198–1200 (accessed 04/04/09).

[69] See generally Matthews 2005, p. 420; Paas 2009, p. 609; Watson 2009, 154 et seq. See also Tuosto 2004.

[70] This is usually possible especially with pharmaceutical product markets where TNC engage in the practice of differential pricing of their products across the different markets.

A further flexibility derives from Article 31, which provides for *'other use'*[71] of the subject-matter of a patent 'without authorisation of the right holder' where such use relate to compulsory licensing, government use and in addressing restrictive business practices. The compulsory licensing system under that provision gives WTO members the right to authorise the use of a patented invention by manufacturers other than the patent right-holder. The use of compulsory licences could lead to a lower cost of drug than the equivalent patented products whose price in the regular market may be too high. The effect of this provision is at the core of the balance of rights between the largely market oriented and profit driven private pharmaceutical industries and the developing country efforts to provide cheap generic medicine for their populations.

The provision however lists series of conditions that must be met for issuing a compulsory license. For instance under Article 31(f) the licensees could only use the patented invention for the benefit of their own domestic market. This condition affects LDC countries which have no potential to support manufacturing in the pharmaceutical sector under compulsory license.[72] The WTO Members, sought to overcome this obstacle in 2001, by adopting the Doha Declaration[73] which clarifies the role of compulsory licences. Paragraph 5(b) of the Declaration affirms the right of WTO Member States to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted. In effect, other than conditions of national emergency, public non commercial use and anti-competitive practices, (which are included in Article 31), the members could obtain the licenses on the basis of any public health situation; and they reserve the right to decide the kind of situations they will classify as a national emergency or circumstance of extreme urgency.[74]

Similarly by an Implementation Decision adopted as on 30 August 2003, the WTO Members waive the Article 31(f) obligation under the compulsory licenses to allow manufacturing countries to export generic medicines to other countries if the exported medicines meet the public health needs of the countries importing them. The importing country must clearly state the exact amount of medicines they intend to purchase and the pharmaceutical companies should employ specific labelling, packaging, and marketing mechanisms, to ensure that the companies will only export the designated medicines to countries that obtain the compulsory licenses.[75]

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[71] 'Other use' refers specifically to use other than that allowed under Article 30 and includes use by the government or third parties authorised by the government.

[72] Note that under this article, exportation countries could not sell their products that made under the compulsory license to other countries more than what should be supplied in the domestic market. See Abbott 2002, p. 499.

[73] See Declaration on the TRIPS Agreement and Public Health, WTO Ministerial Conference, Fourth Session, Doha, Adopted on 14 November 2001, WT/MIN(01)/DEC/2.

[74] TRIPS Article 31(b) and (k); Haochen 2004, p. 137.

[75] On the implications of the application of the Decision, see Paas 2009, pp. 612–613.

9.2.1.3 The TRIPS, PPP Concept and LDC Health Services

What emerges from the WTO developing members' commitment to ensure protection and enforcement of nearly all forms of IPR[76] of their developed counterparts, who are predominantly IPR-holders, is a sort of 'thy-brother's-keeper' partnership which could pose challenges particularly for LDCs. The foregoing analysis undoubtedly show that the WTO rules on TRIPS hold profound implications for the concept of PPP both from a context of 'public private for profit partnerships' and from the non-commercial and non-competitive developmental context PPP. The latter context will invariably represent a PPP for a government purpose to provide or facilitate, inter alia, accessible and affordable pharmaceutical products, and health technology for their citizens on a non-commercial basis. But the LDC governments would need to collaborate with the private sector on their approach to medicines or medical technology, where they desire to use the TRIPS flexibility provisions to overcome IPR constraints.

Similarly, cooperation and collaboration would be required between WTO developed country governments and their private enterprises on the one hand and LDC governments on the other, for the purpose of addressing public health problems afflicting many LDCs, especially those resulting from HIV/AIDS, tuberculosis, malaria, and other epidemics. The Doha Declaration stresses the need for the TRIPS Agreement to be part of the wider national and international action to address these problems.[77] That Declaration and subsequent Decisions pave the way for a new kind of PPP arrangement that potentially reposition economic interests of the developed countries and rebalances the rights of their pharmaceutical industries in order to address public health challenges facing LDCs.

Such partnership derives not from the traditional PPP models with its market based underpinnings, but from the pursuit of shared goals of addressing LDC public health needs through cooperation between the public and private entities. Under this partnership, the LDC are accorded waivers and dispensations including grace periods from patent protection. For example the poorest countries are not obliged to implement, apply, or enforce the TRIPS obligations on patents before 2016, instead of the originally scheduled date of 2005. Developed members also commit to provide incentives to their enterprises and institutions to promote and encourage technology transfer to the LDC members pursuant to Article 66.2.[78]

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[76] Including over knowledge, research and development of health related technology, patented pharmaceutical products and processes, medical/clinical procedures.

[77] The Doha Declaration supra n. 73 paras 2 and 7.

[78] Decision on Least-Developed Country Members—Obligations Under Article 70.9 of the TRIPS Agreement with Respect to Pharmaceutical Products (8 July 2002); Decision on the Extension of the Transition Period under Article 66.1 of the TRIPS Agreement for Least-Developed Country Members for Certain Obligations with Respect to Pharmaceutical Products; and Decision on Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and public health (30 August 2003); paragraph 7 = all available at http://www.wto.org/english/tratop_e/trips_e/pharmpatent_e.htm (last accessed 8/05/09).

More recently, the Paragraph 6 system (established under the General Council Decision of August 2003) was given effect for the first time in September 2008 to ship generic medicines from Canada to treat HIV/AIDS patients in Rwanda.[79] It is alleged that access to medicines has improved through a major reduction of prices enhanced by international funding.[80] It is schemes like this, which underscore Tuosto's laud for the benefits of making available medicines to LDC otherwise than through the transfer of technology or foreign investment.[81] But caution should be exercised in over-emphasising the benefits of drug availability in the LDC outside local production capacities and not down play other important domestic policy tools (like direct investment and industrialisation) which are necessary to pursue health goals within a broader economic development agenda. As Andrew Lang effectively puts it, a distinction ought to be made between accounts of the social impacts of international trade itself and the analysis of the impact of international trade regime on the policies making purposes of its members—demarcating social from political impact of trade regimes.[82] This suggestion is useful for navigating the cross-road between the TRIPS agreement and the economic activities that impact LDC public health challenges.

What is clear from this analysis of the TRIPS Agreement in relation to the concept of PPP and the implications for public health in poor countries is a bias in favour of private involvement in public health service provision predominantly on a commercial platform, but also from a cooperative and collaborative framework that will allow LDC to meet precarious health challenges. There are also so many conditions to the WTO solutions which seek to ensure that the TRIPS flexibility provisions do protect public health as oppose to the pursuit of industrial and commercial policy objectives. But the prevalence of these conditions seed some doubt over their effective implementation. This scepticism is further compounded by the practice of bilateral trade agreements between developed and developing countries which tend to impose stronger provisions and additional limitations than those available under the TRIPS and de facto could make the use of the WTO flexibilities more difficult.[83] These short comings no doubt influenced calls for the millennium development strategy which combines 'trade and aid for development' on the rationale that the TRIPs provisions should be complemented by aid in the form of subsidised purchases of essential medicines.

Ultimately, it seems that what started off as a predictable rule-based WTO/TRIPS and public health issue has transformed, whether by design, coincidence or unforeseeable consequence, into an international and global public–private policy

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[79] Pascal 2008. WTO News: Speeches at http://www.wto.org/english/news_e/sppl_e/sppl111_e.htm (accessed 08/03/2009).

[80] Ibid.

[81] Tuosto 2004, p. 542.

[82] Lang 2007, at pp. 345–346.

[83] For example the US uses bilateral pressure under Section 301 to address exhaustion issues; see Messerlin 2005, pp. 198–200.

issue, that is fanned by a cosy alliance of political, economic and moral considerations, and operative outside the remit of rules, rights and responsibilities. The important question now is: whether the anomaly and regulatory paradox of the *global partnerships for health* have a 'collocation agreement' with the WTO, or is it to be explained simply as the practice for the WTO to support the political policy objectives agreed upon by its members?

9.2.2 International and Global Health Partnerships

International and global partnerships on health (IHPs) have the objective of addressing constraints to the health MDGs. They ensure international cooperation and collective responsibility for achieving the MDGs and translating such cooperation into action. IHPs facilitate increase in aid flows or alternative source of health financing that is channelled through the 'Global Fund' that was set up with express purpose of raising money from governments, private individuals, and the corporate sector. This global responsibility essentially necessitates cooperation, collaboration, and coordination between wide variety of public and private actors in partnerships at varying levels of interests and engagement. In this section I examine relevant IHPs and their activities in LDCs.

The main IHP initiatives are: The *Global Fund to Fight AIDS*, *Tuberculosis*, *and Malaria* (GFATM); The *Global Alliance for Vaccines and Immunisation* (GAVI); The World Bank *Multi-Country HIV/AIDS Program* (MAP); The United States *President's Emergency Plan for AIDS Relief* (PEPFAR); The *Roll Back Malaria*, *initiative* (WHO/RBM); the *Stop Tuberculosis Partnership*; Research and development PPPs; and *Initiative on Public–Private Partnerships for Health* (IPPPH).[84]

The GAVI Alliance is an example of 'spaghetti bowl' of PPP cocktail. In the mix are:

- Developed country donors—ensure that health receives an adequate proportion of ODA and also contribute to technical and policy expertise;
- Developing country governments—recipients of Aids vaccines;
- International organisations—(WHO and UNICEF) support countries in their application for GAVI funds, including monitoring of GAVI-related immunisation activities;
- Research and technical health institutes—who provide technical staff for operations and help build capacity for research and development;

[84] See generally Eldis 'Health and development Information Team' (Eldis HAI Team) available at: http://www.eldis.org/go/topics/resource-guides/health-systems/global-initiatives-and-public-private-partnerships/public-private-partnerships—Information on all the relevant initiatives can be accessed through this site. (last accessed 04/06/09).

- International financiers (World Bank)—expanding its loans and credits in support of immunisation and enhancing its policy dialogue with ministries of finance, health, and other partners to recognise the value of immunisation and new vaccine development;
- Industrialised country vaccine industry[85]—ensures pool of global expertise for development and distribution of new and under-used vaccines and accessibility to vaccines especially for children of poorest people and countries;
- Developing country vaccine industry—through DCVMN[86]—shape a broader, healthier global vaccine market and to improve vaccine affordability;
- Private sector philanthropists (The Gates Foundation) and civil society organisations.[87]

Several innovative mechanisms continue to inform international IHP under the GAVI.[88] Under the Advanced Market Commitment (AMC) mechanism for example, donors commit money as incentives to vaccine makers in order to guarantee the price of vaccines once they have been developed. Companies that participate in an AMC make legally binding commitments to supply the vaccines at lower and sustainable prices after donor funds made available for the initial fixed price, are spent.[89] As observed by Micklewright and Wright, 'Health looks especially attractive to large donor looking for a problem that can be solved by funding a 'technical' solution.'[90]

Then there is the so-called 'ethical investment' for health development goals. HSBC, in collaboration with the International Finance Facility for Immunisation (IFFIm), the GAVI Alliance and the World Bank, have designed the innovative Vaccine Investment Plan.[91] The initiative ensures that the IFFIm bonds are made available through an ISA, and offered by HSBC in the United Kingdom to raise funds from personal investors and pay them a competitive return for their funds and so to protect children in LDC from life-threatening diseases.[92] The global pool of resources under various initiatives for drug and vaccine research, production, and marketing to the world's poor, whether by donation or price discounting

[85] Examples include GlaxoSmithKline Biologicals; Novartis Vaccine; Merck & Co Inc etc.

[86] Developing Country Vaccine Manufacturers Network (DCVMN) represents a voluntary, public health-driven alliance of enterprises—state-owned and private, large and small—from developing and middle-income countries. (Indonesia, India, Brazil, Senegal, and Korea) All DCVMN are pre-qualified by WHO to supply vaccines both to domestic and international markets, including UNICEF and WHO and GAVI.

[87] Eldis HAI Team supra n. 84.

[88] GAVI Alliance, 'Innovative Partnerships', available at http://www.gavialliance.org (accessed 27/04/09).

[89] Ibid.

[90] Micklewright and Wright 2005, p. 148.

[91] GAVI Alliance, 'Innovative Vaccine Investment ISA', available http://www.gavialliance.org (last accessed 27/04/09).

[92] Ibid. IFFIm has raised more than US$1.6 billion to support GAVI immunisation programmes since 2006.

should be applauded. However, some operational concerns still remain which are addressed hereunder.

In their review of IHPs, Conway et al. recommend that there is the need to develop greater policy coherence among collaborating institutions and donor partners in order to realise positive results.[93] The reviewers further recommend that 'organisations must start to operate with a different mindset, where attribution and control become less important driving forces, replaced by the higher aspirations of achieving the MDG through cooperative *mutual accountability*.'[94] Bernstein and Sessions recently examined the operation of three major funds directed at combating HIV/AIDS in Ethiopia and Uganda.[95] These include the GFATM, the PEPFAR, and the World Banks' MAP. They report that in 2005 alone the three funding bodies disbursed three billion US dollars, through governments, local non-governmental organisations (NGOs), international NGOs, consulting agencies, and other bodies for addressing HIV/AIDS at the country-level. They find that the large scale of the increase in funding, and the difference in disbursement procedures between the three funders, made the new funding difficult to manage in Ethiopia and Uganda.[96]

A similar concern emerges from a study of the health systems in Botswana, Sri Lanka, Uganda and Zambia to assess the role of PPPs in improving access to donated or discounted drugs for diseases including malaria, and HIV/AIDS.[97] Caines and Lush reveal that the relevant LDCs are not given appropriate support at the international arena, to assess for themselves which strategies (discounted/donated) or offers of support (funding) could provide the maximum cost benefit.[98] Even more unsettling is their finding that, for the LDC to benefit from donated drugs precludes, the use of generics while the lack of overall price transparency means that governments were not always sure if or when they could negotiate further discounts from companies.[99]

Moreover, the African strategy in respect of TB Control PPPs, operates within concepts like 'strictly private for profit', 'private for profit' and 'private not for profit'.[100] Examples of 'private for profit' LDCs with the Global Fund support for specific TB PPP include Burundi, Malawi, Liberia, Mali, Mozambique, Senegal, and Sierra Leone.[101] It seems paradoxically strange that amidst the billions that are garnered for disease prevention, control, and research through the Global Fund, LDC countries tend to be grouped according to the nomenclature of profitability for access to affordable TB drugs. Also, Tubman has examined how PPP research and

[93] Conway et al. 2008, p. 7.

[94] Ibid. [emphasis added].

[95] Bernstein and Sessions 2007, p. 4.

[96] Ibid.

[97] Caines and Lush 2004, pp. 4–5.

[98] Ibid.

[99] Ibid.

[100] Nkhoma 2008.

[101] Ibid. On the cost effectiveness of PPP programmes see generally: Yukich et al. 2007.

development agreements with access conditions have been developed, negotiated, and implemented, and how they are structured to ensure the widest effective access to the finished product. He concludes that there is a need to develop new hybrid forms of intellectual property management, which allow public players to negotiate access to effective health delivery, while at the same time providing incentive for private players to develop product research and manufacturing resources.[102]

In light of the forgoing examples, it is not implausible to suggest the appearance of either collusion between the international public partners and their private counterparts to defraud LDC; or that an inherent conflict exists between the commercial interest underpinning health PPP and the goals of public health (in the *developmental context*) that is irreconcilable. There is thus an urgent need for LDC governments to re-examine and refocus their public health priorities to investments in building skills in their health sector, health institutions, and manufacturing capacities, over and above the current system of drug cartelisation that is flagged through international health PPP.

9.3 International Development and PPP

Outside the remit of the IHPs of the global fund and other alliances, donors, NGO, and civil society involvement in LDC health development is still substantial. This may not directly connect with the global initiatives but they are not sufficiently distinguished from it. Currently, apart from cases of humanitarian assistance and transitional processes, the health concerns in MDGs tend to supplant broader health policy framework in LDCs. Development PPP (unlike some Global PPPs) are not merely financial instruments, but are operative locally. In this section I discuss development PPP for health (DPH). I attempt closer scrutiny of partnership (including government) agendas and implementation methods. The goal is to ascertain a *developmental context* of health PPP as opposed to the traditional business-led PPP arrangement that is echoes in other sections of this paper.

9.3.1 Financing for Health versus Financing Healthy Business

In the realm of international development, PPP has become an 'essential tool' in the US government's 'development toolbox' to help the Americas and the world meet the challenges of the 21st century including health care in developing

[102] Tubman 2004 (accessed 26/05/2009). For a corporate perspective on Health PPP in Tanzania, see Njau et al. 2009, pp. 235–249. They identify three key themes that are critical for developing countries to emulate in the implementation of PPPs. They conclude from their case study that '… PPPs may begin from very humble and loose beginnings but with perseverance, a vision, and trustworthiness may become powerful advocates for meeting prescribed health agendas in the developing world.'

countries.[103] The US development model PPP is the USAID concept of 'Global Development Alliance (GDA).[104] The GDA is a business model of public–private alliances that institutes private sector partners as full collaborators in the implementation, design, and funding of development projects including health services. It links the US development institutions—civil society and private (profit-making and non-profit)—with those in the developing world, overlapping business and development interests with traditional NGO and host government partners.[105]

The GDA uses Global Framework Agreements (GFA) to create further strategic partnerships with key private sector partners.[106] This helps to reduce the start-up effort required for creating public–private alliances on an individual basis; and they also help to integrate development outcomes into business agendas more broadly.[107] GDA has 'elevated partnerships from the realm of charitable contributions and corporate social responsibility to focus on core business interests of private firms and long-term investment of private philanthropy.'[108]

But international development PPP go beyond business concerns. It includes health and other social policy initiatives which aim to strengthen the interface between public partners and non-state actors in order to make government more responsive to users of health services. In this regard, philanthropy partnership plays a vital role in international health development especially in terms of addressing or attaining a common health and social goal through development charities and private donations. These are partnered by a wide variety of people or organisations giving gifts or subscriptions without necessarily having control of the direction and outcome of the funds. The private charities could then partner with the international public partners or operate within the beneficiary-recipient developing countries to further the national health priorities identified by the public partners or those within their specific mandate.

Autonomous agencies of the UN undertake development activities with respect to advancing various social development goals including the health MDG. For example, UNICEF, WHO, UNDP, UNFPA being public international agencies, could partner with private individuals, entities or foundation donors and in some cases franchising through national charities.[109] UNICEF promotes a system of allowing national charities otherwise designated as 'national committees' to use

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[103] Green 2008 [emphasis added].

[104] USAID: 'History of the Global development alliance' (USAID GDA) available http://www.usaid.gov/our_work/global_partnerships/gda/frameworks.html. The alliance leverages more than $9 billion in combined public–private sector resources.

[105] Ibid.

[106] For example, USAID/GFA partners with Microsoft Corporation, the Millennium Challenge Corporation and the US President's Emergency Plan for Aids Relief (PEPFAR) combined resources, to advance activities globally in six key areas including health.

[107] USAID GDA supra n. 104

[108] Ibid.

[109] Micklewright and Wright 2005, p. 148.

the name and logo of the agency in order to raise money.[110] This arrangement should not be confused with government contributions to UNICEF or WHO, and must also be distinguished from governments' overall official development assistance channelled through regional or national development agencies which may (or not) be operational at country level. Examples include EC-EDF, DFID, and IRISH AID.

Further forms of international development partnership have been identified by Micklewright and Wright in forms of 'corporate giving' particularly with reference to MNCs. This is taking place in two areas, namely 'cause related marketing' (CRM) and corporate social responsibility (CSR).[111] CRM is derived from corporate recognition that an association with worthy cause can benefit their brands. According to them, it is 'a commercial activity by which businesses and charities or causes form a partnership with each other to market an image, product or service for mutual benefit'[112] CSR is linked with firms building its reputation through investing in social goals from its 'core budget' as opposed to a 'peripheral benevolence fund'.[113] Such act of partnership through a sense of social responsibility is commonly exemplified in MNCs commitments to improving the health of their work force in LDCs by building health clinics.

The analysis has revealed complex mix of partners, with variable structure and models of PPP in international financing relevant to health development. The United States GDA business model of public–private alliances overlaps business and development interests and links the developing world through so called 'global framework agreements'. Then, there is the health and other social policy oriented PPP between international public partners and non-state actors who may not necessarily have control of the direction and outcome of the funds. We also have autonomous public international agencies of the UN partnering with private individuals, entities or foundation donors to undertake health development activities. There is also the developed government overall official development assistance that is channelled through regional or national development agencies. Further partnership derives from forms of 'corporate giving' evidenced through CSM or CSR schemes. The legal aspects of such partnerships in terms of obligations, enforceable rights, duty, and accountability to the LDC is not always visible or certain which leaves the respective arrangements pretty much on the faith of 'to thy own self be true'.

The following section will examine the extent to which the varying categories of DPH identified in the forgoing analysis are representative of donor activities in Sierra Leone's health sector.

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110 Ibid.

111 Ibid.

112 Ibid.

113 Ibid.

9.3.2 Government Services, Development Partnerships and Regulatory Paradoxes

Donors make a significant contribution to health sector budget in Sierra Leone. There are 96 registered Health partners operating in the country as Donors (international public institutions and agencies), NGOs (international, national or mission NGOs) with a declared annual cost of operation totalling millions of dollars in 2008.[114] Recently further resources have been mobilised to support a new Reproductive and Child Health (RCH) strategy (2008–2010), aimed at reducing child mortality and improving maternal health- (MDG 4 and 5). Funds have been pledged by the World Bank, DFID, and technical assistance from UN agencies. The range of public and private participants acting on 'common-but differentiated-goals' and responsibilities in a reasonably small health sector as Sierra Leone does have implications for governments' health care policy planning, and financing, implementation, and regulation.

Regulatory tensions and strains are prevalent in health development financing. There is difficulty on how to reconcile vertical approaches, which create and utilise managerial, operational and logistical structures as separate health initiatives on the one hand, with those of government health system initiatives including those that address disease prevention and control.[115] This situation is believed to have created a '*power culture*' as opposed to a *'task culture' in Sierra Leone's health sector*.[116] A new model of health sector financing known as Sector Wide Approaches (SWAps) is currently instituted. According to UNICEF, the rationale is to ensure that the major funding contributions for the health sector support a single plan for sector policy, strategy, and expenditure backed by government leadership.[117] SWAps were created for several purposes, namely:

- to address the limitations of project-based forms of donor assistance;
- to ensure that overall health reform goals are met;
- to reduce the large transaction costs for countries and establish genuine partnerships between donors and countries;

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[114] MOHS/SL *A Hand Book of Health NGOs, Donor Partners in Sierra Leone*, January Sierra Leone Government, MOHS Youyi Building Freetown (2008). The Main Donors and the amount of funds committed by each public partner for the year 2008 alone is as follows: EU (40 million Euros), DFID (40 million pounds), JICA (5 million and 7 hundred thousand dollars (USD) and Irish Aid (1 million USD). The GFMAT has now pledged up to 50 million (USD), while the World Bank IDA grant is 30 million (SDR). The main international NGOs are: Oxfam UK (7 million pounds); CARE International (4 million USD); Concern World Wide/SL (1 million and 400 hundred thousand Euros). Note that the regulatory requirement is for NGOs to disclose statement of accounts, but the Partners have refused to provide a complete outlay of their spending.

[115] UNICEF 2008 (last accessed 04/03/09).

[116] Siegel et al. 1996 (also in Govt of Sierra Leone, MOHS Staff Appraisal Report No. 13947-SL) Freetown (Dec. 1997).

[117] UNICEF Report (2008) supra n. 115, at p. 106.

- to adopt common approaches to health service delivery across the sector;
- to ensure that government procedures are made to increasingly control the disbursement and accounting of funds.[118]

Concerns still remain over rationalising and reconciling donor and GOSL accounting, procurement, disbursement, and auditing requirements.[119] In terms of project support and implementation, PPP is the main mechanism used in the fight against Malaria, HIV/AIDS, and TB. These three initiatives are prioritised to benefit from huge allocations from the Global Fund. It is therefore not surprising that about 90% of the listed NGOs (including NGO clinics) in the health sector are inscribed as having expertise or operational mandate in these areas, with the highest being for HIV/AIDS.[120] The recently launched RCH programme is reportedly the current attraction and darling of international NGOs partners.

According to the MOHS Donor Liaison Officer, the Ministry finds it difficult to regulate this trend because it filters from the international policy and financing mechanism and instruments through to particular NGO from the funding countries.[121] Such a measure is pursued by JICA, which uses its contribution of 850 million(USD) to the Global Fund to foster the participation of Japanese NGOs in STOP TB Control efforts in Sierra Leone and other efforts conducted by international organisations.[122]

The malaria initiative is a useful example of PPP collaboration on implementation. According to the UNICEF Executive Director, wide spread distribution of insecticide-treated nets is a significant factor in altering the trend of 100 million people dying of malaria a year.[123] So Sierra Leone's main strategy for Roll Back Malaria (RBM) is in using PPP to promote the use of Long Lasting Insecticidal Nets (LLINs) in the fight against malaria.[124] Even the recent World Bank IDA

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[118] Ibid., at p. 106.

[119] Siegel et al. 1997; see also Canavan et al. 2008. Commissioned by the Health and Fragile States Network in Collaboration with the Royal Tropical Institute, Amsterdam October 2008, 1–80 especially 13–39 at http://www.kit.nl/net/KIT_Publicaties_output/showfile.aspx?e=1484 (09/05/09).

[120] There is limited information on the prevalence of HIV/AIDS in Sierra Leone. However a modelling exercise carried out for the World Bank calculated the annual cost of scaling-up AIDS programmes to meet the current need to be between US$ 9–14 Million USD. This represents per capita cost of around US$ 2-US$3 and approximately 1.8% of GDP (Landell Mills 2007 at p. 55).

[121] Fofana supra n. 35.

[122] Ministry of Foreign Affairs of Japan Public–Private Partnership for International Cooperation towards the Elimination of Tuberculosis 24 July 2008; available at: http://www.stoptb.jp/english/pdf/StopTB%20Japan%20Action%20Plan.pdf (accessed 02/04/09).

[123] UNICEF—Executive Director UNICEF World Malaria Day Announcement by: http://www.gawkk.com/unicef-world-malaria-day-2009-announcement-1/discuss

[124] Creating Sustainable Impact Through Public Private Partnerships In The Fight Against Malaria, Roll Back Malaria, *Scaling up Insecticide-treated Netting Programmes in Africa*, August 2005.

Agreement ensures the use of this product as measurable outcome of the Governments' evaluation and reporting obligations in terms that:

> the number of insecticide-treated bed nets purchased under the project and distributed to the population exceeds 160,000 and the percentage of children under five years of age and pregnant women … who sleep regularly under insecticide-treated bed nets, is at least 40% each.[125]

The government policy of free LLIN distribution is now the problem because it jeopardises the market–based programmes of private partners, social marketing, and other commercial interest in the PPP that is promoted by international public and private partners including the World Bank.[126] The government partners in the Sierra Leone RBM initiative include:

- Ministry of Health & Sanitation—National Malaria Control Programme (MOHS/NMCP) Government of Sierra Leone:—owners of the health program;
- The World Bank (WB)—funding the social marketing and distribution program;
- Universat Logistics Company (ULC)—the local distributor implementing the social marketing program and being supported to build capacity for eventual commercial operation;
- Vestergaard Frandsen S.A.(VF)—Vestergaard Frandsen S.A.(VF)—supplier of PermaNet® LLINs and funding agent for commercial marketing activities;
- Canadian International Development Agency (CIDA)—funding Measles and Malaria Initiative Canadian Red Cross (CRC)—implementing the Measles & Malaria Initiative (MMI);
- Other donors/stakeholders—Participating in campaigns: Médecins Sans Frontières (MSF), CARE International and the Sierra Leone Red Cross (SLRC).

This DHP model aims to collaborate closely for promotion of LLINs' in order to close the gap between free public distributions and time limited subsidised approaches, and sustainable market development.[127] The WHO and the EU ensured that the GOSL waived tariffs and taxes on mosquito nets, insecticides, and anti-malaria drugs, so to address the need of other groups of people not catered for under the Government Policy for Vulnerable Groups.[128] But in this

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[125] World Bank/SL HSRD Project supra n. 36 [emphasis added].

[126] Roll Back Malaria Partnership 'Creating Sustainable Impact through Public Private Partnerships in The Fight against Malaria', Roll Back Malaria, *Scaling up Insecticide-treated Netting Programmes in Africa*, August 2005 at http://www.gbcimpact.org/files/transfers/Sustainable_Impact_Sierra_Leone_Allan.doc (06/05/09). See more generally—Roll Back Malaria Partnership: Working Group for Scaling-up Insecticide-treated Netting 'A Strategic Framework for Coordinated National Action, Roll Back Malaria, WHO Geneva, Switzerland available at http://www.rollbackmalaria.org/partnership/wg/wg_itn/docs/WINITN_StrategicFramework.pdf (06/05/09).

[127] Ibid.

[128] MOHS/SL 'Mission, Objective, Achievements and Aims of the Malaria Control Programme', 11 August 2006, http://www.health.sl/drwebsite/publish/page_46.shtml (accessed 04/03/09).

dispensation no strict distinction is made between nets under market targeted programmes or social marketing schemes. Also two important factors are not considered in the arrangement: how they afford the nets for the poorest households; and the fact that the effectiveness of the insecticide treated nets declines after 3–4 years.

Similarly, some legal complications could also arise in implementation method that impact on the government's health services regulatory efficiency. For example, there is inherent conflict between the Hospital Boards' Act, 2003 and the Local Government Act, 2004 (LGA). Both legislation effectively confer the same authority to different administrative functionaries and empower both over financial matters, including procurement services, to raise loans and to award contracts.[129] This anomaly is seemingly taken advantage of by the international Donor partners who are keen on instituting un-planned and un-sequenced decentralisation process, and their NGOs who would gladly operate within an unregulated framework. For instance, a DFID award (GB£ 782,043) was made directly payable to CARE International for the implementation of the new RCH initiative on the justification that it would allow NGOs already active in the field to continue to contribute to RCH as the government establishes a functional contracting system.[130] Sierra Leone's official position is that these methods inhibit transparency, accountability, effective regulation, and monitoring of outcomes of such arrangements, the responsibility and risk of which always remains with the government.

This outlook illustrate that the government health sector benefits as much from its DHPs as it is challenged by their predominance in the sector. It puts in sharp focus the need for an effective regulatory mechanism to ameliorate the challenges—especially for regulating health NGOs or charities. One such mechanism could be in finding a criterion to applying incentive systems, as opposed to the prevailing measure which is based on share of expenditure cost, and, huge duty and tax waivers. Sierra Leone could consider adopting the measure adopted by the United Kingdom in its 'Millennium gift aid' scheme between 1998 and 2000 as a useful guide.[131] Under such scheme, in order to qualify for tax deductibility, donations had to be to 'UK charities' running projects in the areas of health, education or poverty-relief in eighty countries eligible for IDA/IBRD funding from the World Bank.

[129] GOSL/MOHS—Report (2005).

[130] CARE International—Project Proposal: Joint Reproductive and Child Health Programme, 'A Collaborative approach to Reducing Maternal and Child Mortality in Sierra Leone', submitted to DFID UK, 20 November 2008.

[131] Micklewright and Wright 2005.

9.4 Conclusions

This chapter sought to identify within the concept of PPP the *developmental context* of government health services in LDCs. It has examined the doctrine of PPP and evaluated its application to LDCs' health delivery systems through various models including the developmental context. The analyses on international trade and economic arrangements reveal that the development context of PPP could be possible within the WTO services and IPR arrangements provided commercially oriented partnerships can be sufficiently distinguished from it. The international and global health partnerships uncovers some contemporary innovative mechanisms for facilitating increased aid flows for funding a 'technical' solution to health problems, albeit with vital operational concerns remaining. The analyses on IDP expose complex mix of partners, with variable structure and models of PPP in international financing for health development. The legal aspects of such partnerships in terms of obligations, enforceable rights, duty, and accountability to the LDC is not certain which leaves development PPP pretty much on the faith of 'to thy own self be true'. The respective distinctions of PPP are implicated in Sierra Leone's health sector. The country benefits as much from its DHPs as it is challenged by their predominant involvement in its health sector. The regulatory tensions and strains that are prevalent in health development financing find easy accommodation in Sierra Leone.

Overall, there seems to be an inherent conflict between the commercial interest underpinning health PPP and the goals of public health (in the *developmental context*) that is irreconcilable. There is also a paradox in having aid funds channelled through 'public–private for profit partnerships' and the fact of legal ambiguities on the rights and obligations of partners is a travesty. The health PPPs tend to predicate on gain and the pursuit of partner self interests. While not entirely adverse to the prospects of gain underlying partnerships generally, in the developmental context this element could undermine LDC governments' genuine effort and national endeavour to provide accessible and affordable health delivery system for their population. It brings into the equation important considerations like: what standard could one use to measure gains?—is it to be measured by the overall wellbeing of a state's population or designated 'vulnerable groups'? Should the gains be measured by selective project gains as 'little-drops' in filling the ocean of health challenges? Should it be measured by good donor relations with consequential implications for other sectors of the economy; or by the politics of how much aid a government can attract? All of these questions represent differing goals, values, and perceptions on how to realise health development goals in LDCs. While these goals and values may still somehow work into partnership agreements for health development, it is imperative that LDC governments are reserved explicit right to use choice of regulatory mechanisms and provide institutional capacity to meet the health challenges they face.

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