Disguising Trade in Development Partnerships[1]

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Abstract. Public-private partnership (PPP) once christened to improve on quality and economic efficiency of public services in developed countries, is now widely promoted as a development tool that could ensure basic social services in LDCs. This paper analyses the doctrine of PPP and the application of various models to LDCs health delivery systems. It examines different types of PPP arrangements including in international trade, other economic arrangements, development PPPs and domestic health initiatives. Examples are drawn from LDC countries especially Sierra Leone, to illustrate the practice of respective health PPPs and regulatory challenges inherent in complex PPP mix. A crucial issue is the appropriateness of marketing 'Public-Private for profit partnerships' as a development mechanism for health delivery in poor countries. The paper recommends a more pro-active role for LDC governments in the design, implementation and surveillance of health PPPs as essential in achieving health development goals.

1 Introduction

The doctrine of public-private partnership (PPP) was christened to improve on quality and economic efficiency of public services in developed countries through collaboration between public and private entities, and using market-based solutions. It remains the favourite brand in capitalist relations. Respective roles of the public and private sector worldwide were altered with the wave of the British experiment with large-scale privatization programmes in the early 1980s, which ushered the engagement of private firms in productive activities.[2]

In LDCs, this has been determined mainly by pressure from international donor agencies (where aid has been conditional on privatization) and from domestic capital market interests at the expense of transparency.[3] Infrastructure development and extractive industries were targets for private sector involvement in LDC public sectors. PPP concept re-brands privatization in an aggressive bid to ensure predominant private sector participation in government service to complement the trend of liberalisation and globalisation.

The concept bears no legal definition. Various terms and models define or describe PPP arrangements. These range from the legal regime determining the nature of partnership, institutional framework governing operations and the regulatory conditions that border partnership interests. The predominant policy objectives driving PPPs relate to private sector development, enabling business environment promotion of competition and social regulation, and international cooperation on these. Within this market centred rationale, embedded legal complexities and regulatory conundrum, PPP is widely promoted as a *development tool* that ensures basic social services including Health in LDCs.

The state of most LDC health sector including Sierra Leone is deplorable. Inadequate government health infrastructure, poor service conditions, prevalence of diseases, and compounded by poverty paint a grim picture for marketing. According to recent UNICEF Report Sub-Saharan Africa region (home to majority of LDCs) is furthest behind on almost all of the health related Millennium Development Goals (MDGs).[4]

It is in light of this peculiarity, that I scope a *developmental context* of health services 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 peoples.

[♣] An earlier version of this paper was published in Kierkegaard, S. (2009) Legal Discourse in Cyberlaw and Trade.IAITL. pp.491-511

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

[3] Ibid p.5

[4] UNICEF *The State of the world's children* (2008).33ff (UNICEF Report) http://www.unicef.org/sowc08/ accessed 8/05/09

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'.[5]

LDC governments have relied on Official flows over the years, including loans, grants, export credits, and publicly guaranteed debt to fulfil this public purpose. However *the* trend of decline in official flows to LDCs, and substantial increase in unofficial private for-profit finance and other private cross-border giving noted by Harford *et.al* [6] contorts the performance of this function. And concerns over global health security ultimately paved the way for a reconditioning of LDC health objectives as a global agenda. Henceforth LDC health challenges should be addressed in '*global partnership'* with collective responsibility particularly for reducing child mortality, improving maternal health, combating HIV/Aids, malaria and other diseases.[7] International cooperation with pharmaceutical companies is made an essential component of this partnership.

This globalisation of partnership introduces the doctrine of PPPs in LDC health service delivery systems in a transformational way that blurs the distinction between the traditional economic orientated PPPs and *developmental context* of health services for LDCs.

This paper, seeks to identify within the concept of PPP the *developmental context* of health services in LDCs. It analyses the doctrine of PPP and the application of various models to LDCs health delivery systems. It examines different types PPP arrangements under broad categories including, international trade and economic partnerships, development PPPs and domestic health initiatives. Examples are drawn from LDC countries, especially Sierra Leone, to illustrate the practice of respective health PPP. Regulatory challenges inherent complex PPP mix is also addressed. The paper recommends a more pro-active role for LDC governments in the design, implementation and surveillance of health PPP as essential in achieving health development goals.

The following section analyses various permutations of PPPs in aid of extrapolating a *developmental context* of health services applicable to LDCs.

2. Doctrine of Public-Private Partnerships

The United Kingdom Private Finance Initiative of the 1990s attempted a systemic programme for PPPs focusing on limiting public expenditure and much later, placing emphasis on public purchase of quality services and risk allocation.

Under EU Community law, PPP enjoys prominence through concepts of SGI and SGEI[8] 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 PPPs.[9] In general, the term PPP in Community usage 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.[10] According to the European Commissioner for Internal Market and Services, it is still unclear how existing 'patchwork quilt' of rules should apply to PPPs.[11] 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 PPPs can work most efficiently.[12]

A UN Study Group defines Public-private partnership 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 realization, and a supportive policy and institutional framework".[13]

The United States National Council for PPP views PPP as contractual relations between public agency and a private sector entity for purpose of the sharing of skills, assets, risks, and rewards potential of each sector in

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

[6] Harford T., *et.al* (2005) pp1-2; 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.

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

[8] SGI is 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- The Commission, "Services of general interest in Europe" (2001/C 17/04) *EN Official Journal of the European Communities* C 17/7 19.1.(2001)

[9] 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

[10] Ibid (emphasis added)

[11] McCreevy C., (2005)

[12] Ibid

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

delivery of service or facility for the use of the general public.[14] From the United States perspective, PPP does not represent "corporate philanthropy" or "charity work" to help poor nations but informs a cooperative alliance that can *benefit business* and the society in which the business operates.[15]

For the African Union (AU) and its New Partnership for African development (NEPAD) agency, PPP represents a means to 'achieving economic transformation in Africa by working closely together with the private sector in utilizing respective core competencies to form synergies and achieve results collectively'. It has also a role in increasing public financing for provision of basic infrastructure - roads, energy, and water supplies and advancing the African Agenda under WTO and EPAs.[16]

In other forums, a social dimension of PPPs is shaping and identified 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.[17] PSPP covers cooperation models between participants that are not only agencies of the state and private enterprises (as in PPP), but are also social enterprises and social economic organizations.[18] 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.[19] 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'.[20]

The forgoing permutations of PPP are split on emphasis – business or 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 promotion of quality, affordable, accessible and universal health care services to citizens as a public purpose for which the government is to provide, facilitate and regulate.

2.1 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 and facility arrangements involving construction, ownership type, management, operation and maintenance, and other financing agreements. These are notably:

- *Build-Own-Operate (BOO)*- private firm builds, owns, and operates a public hospital
- *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
- *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
- *Design-Build-Maintain (DBM)* - private partner designs, constructs & has responsibility for maintenance of the facility; but ownership of asset remains with the public agency
- *Purchase-Leaseback* - the private firm finances and builds a new public hospital then leases it back to the government
- *Contract Services for Operations, Maintenance and/or Management*- transactions involving private management of a public hospital- out sourcing support services (clinical, non-clinical and specialized), procurement of labour, medicine, equipment; and technical expertise. Also *collocation agreements* in which a private wing is located within or beside a public hospital

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

[15] Eric Green "Public-Private Partnerships Maximize Development Assistance": accessed 06/04/09 http://www.america.gov/st/foraid-english/2008/August/20080818171615xeneerg0.7114527.html#ixzz0DzE1p1Lp& (2008)

[16]Declaration The African Private Sector Forum: 22-23 January, (2008); Addis Ababa, Ethiopia p.4; http://www.commit4africa.org/declaration/assembly-african-union-12th-ordinary-session-addis-ababa; NEPAD Business Group: African Union pursues stronger public-private sector partnership June (2004)

[17]"Public/social/private partnerships are methods of co-operation between private and government bodies". http://www.answers.com/topic/public-social-private-partnership#From_PPP_to_PSPP (PSPP); Also http://en.wikipedia.org/wiki/Public_Social_Private_Partnership both accessed 28 /05/09

[18] Ibid

[19] Ibid

[20]Ibid

- *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.
- *Developer Finance-T*he 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)
- *Turnkey Model* The private developer commits to build the facility for a fixed price and absorbs the construction risk of meeting that price commitment.
- *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. [21]
- *'Institutionalized PPPs'* arrangements "outsourcing of public tasks, which involves the creation of public service undertakings held jointly by both a public and private partner".[22]

The forgoing partnering models are more representative of the EC, US and AU permutations - emphasising business environment over the social element and cooperation only between public agencies and private enterprises and focuses on infrastructure, cost and efficiency.

How do the various 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.[23] Each provincial district has at least one (not more than two government hospital (ownership and management). There are twelve private hospitals in six districts operating independent from government- eight are mission hospitals and four are industrial hospitals including the Diamond mining company facility.[24]

The Western Area has two government hospitals, while Western Unban (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. The Choithrams Memorial Hospital represents a Model (d) arrangement – Choithrams designed and constructed the facility, has responsibility for the maintenance of the facility but ownership of asset remains with the public agency. Foreign Indian Doctors operate in it. A variant of Model (f) - collocation agreements exist between GOSL and UNAMSIL (UN agency) and the hospital management. The Government is currently negotiating a collocation agreement between Choithrams hospital and the Italian NGO Clinic - Emergency Life Support for War Victims.[25]

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 restoration of the essential functions of health care delivery system and for strengthening both public and private health sector capacities, so as to improve the efficiency of the health sector.[26] The provisions include *inter alia* rehabilitation of selected hospitals and health centers, acquisition of clinical and related services, procurement of goods and works through competitive bidding, including through '*direct contracting and procurement from United Nations Agencies*'.[27] 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 'economic efficiency' with 'equity' in PPPs? 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 employer

[21] See generally, Taylor and Blaire (2002); Marek T., *et.al* (2003); NC/PPP above n. 13
[22] McCreevy C., (2005)
[23] Two hundred and fourteen of these facilities, (mainly CHC and MCHC) are not functioning and an estimated 100 are needing rehabilitation
[24]Directorate of PHC, *The Primary Health Care Hand Book Policy* Ministry of Health and Sanitation, (MOH/SL): Freetown, SL, May 2007 (PHC Handbook)
[25] See MOHS/SL, *A Handbook of Health NGOs, Donors and other Partners in 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.
[26]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)
[27] Ibid (emphasis added)

insurance schemes? It is a fact that the economic rebalancing that is necessary under transition to PPPs can undermine the basic political and economic goal of most governments – *i.e.* provision of basic needs to the lowest income Groups.[28] The transition can 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 uninsured population in a *Public-private-for-profit-* partnerships. 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 private sector enhancement? 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.

3. International cooperation: Trade and other economic arrangements

The role and nature of PPP in international cooperation of states for pursuit of LDC health objectives are quite complex. First, it does not immediately translate the private component of PPP. Second, there is a dichotomy between interstate cooperation in multilateral and regional institutional settings on the one hand and in bilateral context. Third, 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 'soft law' which is not always coherent. This part examines selected international PPP cooperation models including under WTO rules, especially their role in enhancing LDC health development goals as a governmental purpose.[29]

3.1 PPP and WTO Rules

Cooperation on international trade is important for the health service delivery in LDCs. For example, most LDC WTO member governments lack manufacturing capacity of essential medical products. Also, the context of globalisation of partnerships would require setting up of foreign companies or organisation cross-border for 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. WTO General Agreements - Trade in Goods (GATTS), Trade in Services (GATS) and Trade Related Intellectual Property Rights (TRIPS) can ensure these transactions within prescribed rules, general principles and special policy considerations under the WTO framework.

3.1.1 The Services Agreement (GATS)

Health services applicable under the GATS include "hospital services (i.e. health services delivered under the supervision of doctors), other health services (i.e. ambulance services and residential health facilities), social services and "other" health and social services".[30]

This classification could basically cover PPP facility and services models outlined above. GATS will apply where LDC member governments institute measures that affect trade in health *services*[31] relating to any of the four modes of supply - cross-border supply, consumption abroad, commercial presence and presence of natural persons - stated in Article 2 (a)-(d) of GATS. LDC members could 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 the territory of WTO Member states. [32]

It may be possible under GATS for LDC members to institute Health services PPP in the commercial and market orientated framework. But they may need to circumvent the GATS obligation which require them to give

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

[29] WTO GATS and TRIPS rules are particularly explored.The discourse however precludes in-depth analysis of relevant WTO agreements. - www.wto.org

[30] Medical and dental services, veterinary services and the services provided by nurses, midwives etc., which are grouped separately under "professional services"- See "health and Social services" available at http://www.wto.org/english/tratop_e/serv_e/health_social_e/health_social_e.htm accessed 04/03/09

[31] Article 27(a)) whether in the form of a law, regulation, rule, procedure, decision, administrative action, or any other form

[32] See Article 1:2(c)]; Article 28(d); and Article 28(m) (ii) Generally Smith, R., et al (2008) pp 437- 446 ; Adlung R. & Mattoo A., (2008) pp48-82; at 49 ; Adlung R (2005) p.11

like foreign health services or service providers in the country equal treatment as that afforded to the foreign PPP service providers in their countries or make available to other foreign health service providers the same privileges enjoyed by domestic health service suppliers.[33]

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.[34] 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.[35] More importantly, LDC members may even choose not to schedule their health sector at all and so operate their PPPs outside WTO rules,[36] or could invoke the special LDC needs consideration principle,[37]or the Article 14 policy exceptions for protection of human health especially given the prevalence of diseases. However, it may be that LDC members have undertaken 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.[38] For instance, the prohibition of new or more discriminatory measures is to be applied in accordance with the level of development of the countries concerned both overall and in individual sectors.[39]

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 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" [40]

There is abundant scholarly literature on the definition of 'government service', which is not dealt with here. The interactive offers varying perspectives on whether GATS impinge on the ability of government to provide vital social services. They also proscribe possible policy choices open to WTO members in the area of services regulation.[41] However, as Adlung & 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" [42]

Sierra Leone has market access limitation in relation to all sectors included in its schedules including Health services in terms of "Commercial Presence". It requires that foreign service providers incorporate or establish business locally in accordance with relevant provisions of Sierra Leone laws and, where applicable, regulations particularly with respect to land and building acquisition, lease, rental, etc. It maintains no market access and national treatment limitation over its health sectors other than that in context of professional services, commercial presence must take the form of partnership.[43]

Foreign ventures have to be also competitive and registered institutions in their own countries. This limitation requiring competitive foreign ventures could potentially affect the non-commercial and non-competitive *developmental context* PPP that could be possible. Such discrepancies highlight PPP regulatory paradoxes. It also puts into context Lang's concern over whether measures which may uneasily sit between public and private law obligations and having a 'mixed regulatory/commercial character' are measures for the GATS. [44]

3.1.2 TRIPS Agreement

Under the TRIPS agreement, WTO members commit to ensure protection and enforcement of nearly all forms of intellectual property rights (IPR) including over knowledge, research and development of health related technology, patented pharmaceutical products and processes, medical/clinical procedures of other WTO members. This 'thy-brother- keeper' ideology could pose challenges to LDCs. Governments would need to collaborate with

[33] Article 2:1; (The Non-discrimination -MFN Principle);Article 16 & 17(Market Access & National treatment Specific obligations as inscribed in members Schedules)
[34] Article 20
[35] Article 3 (Transparency Obligation)
[36] Article 5 (Economic Integration)
[37] WTO Preamble Para 3-6 and also Article 4
[38] Adlung R. and Carzaniga A., (2009) p.8
[39] Ibid
[40] Articles 1:3(b) &(c).
[41] Krajewski (2003) 341-367; Adlung (2005); Smith *et.al.* (2008); Adlung and Carzaniga (2001) pp. 352ff Fidler, David (2004)
[42] Adlung & Mattoo (2008) p.52-53; Adlung 2005; Rudolf Adlung and Antonia Carzaniga (2009) p.8
[43] WTO Schedule of Commitments
[44] Lang A. " The GATS and regulatory autonomy: The case study of social regulation of the water industry" JIEL 7 (4) p 813 (see Footnote 36)

the private sector on their approach to medicines or medical technology where they desire to use TRIPS flexibility provisions to overcome IPR constraints. [45]

Similarly, cooperation and collaboration would be required between WTO Developed country governments and their private enterprises on the one hand and LDCs 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 on TRIPS Agreement and Public Health, (Doha), stress the need for the WTO Agreement on TRIPS to be part of the wider national and international action to address these problems.[46] Doha and subsequent Decisions would pave the way for new kind of PPP arrangements that could 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 countries.

Such partnership derives not from the traditional PPP models, but from the pursuit of shared goals through cooperation and provides LDCs with dispensations including grace periods from patent protection and waivers. Developed members also commit to provide incentives to their enterprises and institutions to promote and encourage technology transfer to LDC members pursuant to Article 66.2.[47] 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.[48] According to WTO Director General Lamy, access to medicines has been improved through a major reduction of prices and enhanced international funding.[49]

Tuosto positions the benefits of availability of medicines to LDCs on balance than through transfer of technology or foreign investment.[50] Caution should be exercised in over-emphasising the benefits of drug availability in LDCs outside local production capacities and not down play other important domestic policy tools (like foreign investment and industrialisation) which are necessary to pursue health goals within a broader economic development agenda. In an attempt to down play the impact of the TRIPS regime, Lamy echoes inter alia, the need for infrastructure, and state transparency in developing countries.

According to Lang, 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 policy making purposes of its members – demarcating social from political impact of trade regimes.[51] This suggestion could not find a more useful purpose than navigating the cross-roads between TRIPS agreement and related economic activities that impact LDC health challenges.

To my mind, what started off as a rule -based predictable WTO/TRIPS and public health issue has transformed, whether by design, coincidence or unforeseeable consequence, into an international public-private policy issue, fanned by a cosy alliance of political, economic and moral considerations and operative outside the remit of rules, rights, duties and responsibilities and judicial scrutiny. The *'global partnerships for health'* may not have a 'collocation agreement' with the WTO. It is simply and conveniently the practice for the WTO to support political policy objectives agreed upon by its members.

3.2 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 channelled through "Global funds" set up with express purpose of raising money from governments, private individuals and the corporate sector. This Global responsibility necessitates cooperation, collaboration and coordination between wide variety of public and private actors in partnerships at varying levels of interests and engagement. Micklewright & Wright

[45]Flexibility mechanisms include compulsory licensing, definition of patentability criteria, and permitting exceptions to patent rights (regulatory reviews), regulatory endorsement of test data and parallel importation and exhaustion rights.
See generally- Matthews D. (2005) 420; See also Tuosto C., (2004) 542

[46] Declaration on the TRIPS Agreement and Public Health, adopted on 14 November 2001 by the Fourth WTO Ministerial Conference, Doha, Qatar. Para 2 &7

[47]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) ; Para 7 = all available at http://www.wto.org/english/tratop_e/trips_e/pharmpatent_e.htm (accessed 8/05/09)

[48] Lamy Pascal (2008) (DG of WTO)

[49] Ibid.

[50] Tuosto, C ,(2004) 542,

[51] Lang A., (2007) 336-206 p.345-6

note that "health looks especially attractive to large donor looking for a problem that can be solved by funding a 'technical' solution" [52]

The main IHP initiatives are: *The Global Fund to Fight AIDS, TB and Malaria* (GFATM); *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); *Roll Back Malaria, initiative* (WHO/RBM); the *Stop TB Partnership;* Research and development PPPs; and *Initiative on Public-Private Partnerships for Health* (IPPPH).[53]

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 contribute technical and policy expertise
- Developing country governments - recipients of Aids vaccines
- International organisations – (WHO & UNICEF) support countries in their application for GAVI funds and monitor related immunisation activities
- International financiers (World Bank) - expands loans and credits in support of immunisation and enhances policy dialogue with ministries of finance, health and partners to recognise the value of immunisation and new vaccine development
- Research and technical health institutes - provide technical staff for operations and help build capacity for research and development
- Industrialised country vaccine industry[54]- ensures pool of global expertise for development and distribution of new and under-used vaccines.
- Developing country vaccine industry (DCVMN)[55] – shape a broader global vaccine market to improve vaccine affordability
- Private sector philanthropists (Gates Foundation) and civil society organisations.[56]

Several innovative mechanisms continue to inform international IHP under GAVI.[57] For example under the Advanced Market Commitment (AMC), donors commit money as incentives to vaccine makers and to guarantee the price of vaccines once they have been developed. Companies that participate in 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.[58]

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, designed the innovative Vaccine Investment Plan and Vaccine Investment[59]. ISA is offered by HSBC in the UK to raise funds from personal investors and pay them a competitive return for their funds whilst 'protecting children in LDCS from life-threatening diseases. [60] 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 ethical investments is impressive.

However some operational concerns remain which are addressed hereunder. In their review of IHPs Conway *et al* report that there is the need to develop greater policy coherence among collaborating institutions and donor partners in order to realize positive results.[61] They 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'*[62].

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[52] Micklewright J., & Wright A., (2005) p.148

[53]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 relevant initiatives can be accessed through this site. (last accessed 04/06/09)

[54] Example include -- GlaxoSmithKline Biological; Novartis Vaccine; Merck & Co Inc etc

[55]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 to domestic and international markets, including UNICEF, WHO& GAVI

[56]Eldis HAI Team above n.51

[57] GAVI Alliance "Innovative Partnerships " available at http://www.gavialliance.org (accessed 27/04/09

[58] Ibid

[59] GAVI Alliance: "Innovative Vaccine Investment ISA " available http://www.gavialliance.org (accessed 27/04/09)

[60] Ibid -the initiative ensures that IFFIm bonds can be made available through an ISA. IFFIm has raised more than US$1.6 billion to support GAVI immunisation programmes since 2006

[61] Conway et.al 2008 p.7

[62] Ibid (emphasis added)

Bernstein & Sessions recently examined the operation of three major funds directed at combating HIV AIDS in Ethiopia and Uganda.[63] 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 and international NGOs, consulting agencies and other bodies for addressing HIV/AIDS at the country-level. They find that large scale increase in funding, and difference in disbursement procedures between the three funders made the new funding difficult to manage in Ethiopia and Uganda.[64]

A similar concern emerges from a four country studies involving - Botswana, Sri Lanka, Uganda and Zambia- assessing the health systems impact of PPPs for improving access to pharmaceuticals for donated or discounted drugs for diseases including malaria, and HIV/AIDS.[65] They find that Countries are not given appropriate support at the international arena, to assess for themselves which strategies (discounted/donated) or offers of support (funding) provide the maximum cost benefit. [66] To benefit from donated drugs precludes use of generics while lack of overall price transparency means that governments were not always sure if or when they could negotiate further discounts from companies.

Similarly, in context of TB Control PPPs, Africa strategy operates within concepts like '*strictly private for profit*', '*private for profit*' and '*private not for profit*'.[67] Amidst billions garnered for disease prevention, control and research, LDC Countries tend to be grouped according to this nomenclature of profitability for TB drug access. Examples of 'Private for profit' countries with Global fund support for specific TB PPM include- Burundi, Malawi, Liberia, Mali, Mozambique Senegal and Sierra Leone.[68]

Tubman has also considered how PPP research and 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. The author concludes that there is a need to develop new hybrid forms of IP 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.[69]

In light of the forgoing examples of the state of play, one is tempted to suggest the appearance of either collusion between international public partners and private counterparts or that conflict between commercial interest and public health is just irreconcilable. There is urgent need for health priorities to be re-examined by LDC governments over and above the seeming drug cartelisation, such as to invest in building skills in their health sector, health institutions and manufacturing capacities.

4. International Development and PPP

Outside the remit of the IHPs, Donor, 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.

The subsequent sections attempt closer scrutiny of development health partnerships (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.

4.1 Financing for health vs. financing healthy business?

In the realm of international development, PPP has become an "essential tool" in the U.S. government's "development toolbox" to help the Americas and the world meet the challenges of the 21st century including health care in developing countries.[70]

The US development model PPP is the USAID concept of 'Global Development Alliance (GDA).[71]The GDA is a business model of public-private alliances that institutes private sector partners as full collaborators in

[63] Bernstein M., & Sessions M. (2007) p.4
[64] Ibid
[65] Caines K and Lush L., (2004) pp 4-5
[66] Ibid
[67] Nkhoma W., (Regional Focal Point, WHO/AFRO) (2008)
[68] Ibid
[69]. Tubman A., (2004) Public-private management of intellectual property for public health outcomes in the developing world: the lessons of access conditions in research and development agreements Initiative on Public-Private Partnerships for Health, 2004 at Eldis- HAI Team above n.51
[70] Eric Green Eric Green above n.14 (emphasis added)

the implementation, design, and funding of development projects including health services. It links the US development civil society and private institutions (profit-making and non-profit) with those in the developing world, overlapping business and development interests with traditional NGO and host government partners.[72]

The GDA uses Global Framework Agreements (GFA) to create further strategic partnerships with key private sector partners. [73] This helps to reduce the start-up effort required creating public-private alliances on an individual basis and they also help to integrate development outcomes into business agendas more broadly.[74] 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'.[75]

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 vital role in international health development especially in terms of addressing or attaining common health and social goals through development charities and private donations. These are partnered by 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 international public partners or operate at beneficiary - recipient developing countries to further national health priorities identified by public partners or those within their specific mandate. Also, autonomous agencies of the UN undertake development activities with respect to advancing various social development goals including health – MDG, UNICEF, WHO, UNDP, UNFPA. These, being public international agencies, partner with private individuals, entities or foundation donors and in some cases franchising through national charities.[76] UNICEF promotes a system of allowing national charities designated as 'national committees' to use the name and logo of the agency in order to raise money.[77] 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 etc.

Further forms of international development partnership have been identified in the 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).[78] CRM is derived from corporate recognition that an association with worthy cause can benefit their brands. 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." [79] CSR is linked with firms building its reputation through investing in social goals from its 'core budget' as oppose to a 'peripheral benevolence fund'.[80] 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.

Combinations of the varying categories of development health partnerships identified in the forgoing are representative of Donor activities in Sierra Leone's Health sector, which is examine hereunder.

4.2 Government health services, partners & regulatory paradoxes

Donors make a significant contribution to health sector budget in Sierra Leone. There are one hundred registered health partners operating in the country as donors (international Institutions and agencies) and NGOs (international, national or mission NGOs). These together maintained a declared annual cost of operation totalling millions of dollars in 2008.[81] Recently further resources have been mobilised to support a new Reproductive and

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[71] 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.

[72] Ibid

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

[74] USAID GDA above n. 71

[75]Ibid

[76] John Micklewright & Anna Wright (2005) p.148

[77] Ibid

[78] Ibid

[79] Ibid

[80] Ibid

[81] MOHS/SL *A Hand Book of Health NGOs, Donor Partners in Sierra Leone*, January (2008) --- The Main Donors and the amount of funds committed by each of public partners for the year 2008 alone was: European community (40 Million Euros), DFID, (£ 40 Million), JICA (5.7 Million USD) and Irish aid (I Million USD). The GFMAT has now pledged up to 50 Million

Child Health (RCH) strategy (2008-10), 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 with a total country population of 5.7 million 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 utilize 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.[82] This situation creates a *'power culture* ' as opposed to a 'task culture' in Sierra Leone's health sector.[83]

A new model of health sector financing known as Sector Wide Approaches (SWAps) is currently instituted. The idea is ensure that the major funding contributions for the health sector support a single plan for sector policy, strategy and expenditure backed by government leadership.[84] SWAps were created for several purposes: to address the limitations of project-based forms of donor assistance, ensure that overall health reform goals were met, reduce large transaction costs for countries and establish genuine partnerships between donors and countries. Common approaches to health service delivery are to be adopted across the sector, and government procedures made increasingly to control the disbursement and accounting of funds.[85] However, concerns still remain over rationalizing and reconciling donor and GOSL accounting, procurement, disbursement, and auditing requirements. [86]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 benefit from huge global funds and it is not surprising that about 90% of listed health NGOs (including NGO clinics) are inscribed as having operational mandate in these areas, with the highest being for HIV/AIDS.[87] The newly launched RCH programme is reportedly the current attraction. 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 through to particular NGO from donor funding countries.[88] 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 organizations.[89]

The malaria initiative is a useful example of PPP collaboration on implementation. According to the UNICEF Executive Director, a wide spread distribution of insecticide-treated nets is significant in altering the trend of100 million malaria deaths each year.[90] Sierra Leone's main malaria strategy is in using PPP to promote the use of Long Lasting Insecticidal Nets (LLINs).[91] Even the recent World bank IDA Agreement [92] ensured this as measurable outcomes 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" [93]

(USD), while the World Bank IDA grant is 30 Million (SDR); The GFMAT has now pledged up to 50 Million (USD), while the World Bank IDA grant is 30 Million (SDR).- Main International NGOs are: Oxfam UK (£ 7 Million) ; CARE International ($4 million USD); Concern World Wide/SL (1.4 Million Euros).- Note that the regulatory requirement is for NGOs to disclose statement of accounts but Partners have refused to provide a complete outlay of their spending.

[82] UNCEF *The state of the world's children* Report 2008 available at http://www.unicef.org/sowc08/docs/sowc08.pdf (UNICEF Report 2008)

[83] Bruce Siegel, et al (1997) David Peters, Sheku Kamara, and Health Reform in Africa: Lessons from Sierra Leone, World Bank Discussion Paper,; also Staff Appraisal Report No. 13947-SL.

[84]UNICEF Report 2008 above n. 82 p.106

[85] Ibid p.106

[86] Bruce Siegel, et al (2007); See also Canavan A., Vergeer; P. Bornemisza O., (2008)

[87] Limited information on the prevalence of HIV/AIDS is prevalent in Sierra Leone. However a modelling exercise carried 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. This represents per capita cost of around US$ 2-US$3 and approximately 1.8% of GDP (see p.55 Landell Mills Development Consultants: Sierra Leone EPA Impact Study Project 112-Sierra Leone, FINAL REPORT V.2 2007.

[88] Ibrahim Fofana n.24 above

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

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

[91] 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

[92] World Bank/SL HSRD Project above n.25

[93] Ibid (emphasis added).

The government policy of free LLIN distribution is now the problem because it jeopardizes the market–based programmes of private partners, social marketing and other commercial interest in the PPP. [94] The PPP model aims to collaborate closely for the promotion of LLINs' in order to close the gap between free public distributions and time limited subsidized approaches, and sustainable market development. [95] The WHO and the EU ensured the GOSL waiver of tariffs and taxes on mosquito nets, insecticides and anti-malaria drugs.[96] The two important factors not considered in the arrangement however is affordability of nets for the poorest households (not catered for under the Government Policy for Vulnerable Groups), and what strategy would apply when the resistant effect of insecticide treated nets decline after 3 years.

Legal complications also arise in implementation that impact on 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. [97] This anomaly is seemingly taken advantage of by Donors keen on un-planned un-sequenced decentralisation process and NGOs who would gladly operate within an unregulated framework.[98] A DFID award (GB£ 782,043) was made to CARE International and co-partners for 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.[99] Official position is that these methods inhibit transparency, accountability, effective regulation and monitoring of outcomes of such arrangements, the responsibility of which remains with the government.

In sum, government health services do benefit as much from its DHPs as it is challenged by their predominance in the sector. A mechanism for regulating health NGOs or charities could be finding a criterion to applying incentive systems, as oppose to the prevailing measure which is based on share of expenditure cost and the huge duty and tax waivers which cost governments revenue in poor countries in proportion to benefits received from NGO funds. A measure adopted by the UK in its 'Millennium gift aid' scheme between 1998 and 2000 could be useful guide[100] - *i.e*. 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.

5. Conclusion

This paper, 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 of partnership arrangement and from varying contexts. What emerges from the discourse is mainly the element of gain and to certain extent the pursuit of self interests above a genuine concern for the state of health service system as a national endeavour and responsibility of government to its population. Admittedly, PPPs as with any partnership depend on the prospects of gain by all participants. However in the *developmental context* of LDC health services, it is not clear what standard measures such gains: is it by overall wellbeing of a state's population or designated 'vulnerable groups'? Should the gains be measured by selective project gains as 'little-drops' fundamental in filling the ocean? 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 these represent differing goals and values and perceptions on how to realise health development goals in LDCs, but they still work into agreements for health development. Governments can still reserve the right to use the choice of regulatory mechanisms and provide an institutional capacity to meet the health challenges they face.

[94] 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

[95] Ibid

[96] MOHS/SL 'Mission, Objective, Achievements and Aims of the Malaria Control Programme' Aug 11, 2006, http://www.health.sl/drwebsite/publish/page_46.shtml

[97] GOSL/MOHS - Report (2005)

[98] Ibrahim Fofana, MOHS/SL Donor Liaison Officer; Also Edward Kamara Permanent Secretary, MOHS/, Freetown, Sierra Leone

[99] CARE International - Project Proposal: Joint Reproductive & Child Health Programme 'A Collaborative approach to Reducing Maternal and Child Mortality in Sierra Leone'- Submitted To: DFID UK, 20 November 2008

[100] John Micklewright & Anna Wright (2005)

Reference

1. Adlung R. & Mattoo A., "THE GATS" in *A Handbook of International Trade in Services*, A Mattoo et.al (eds) OUP (2008)
2. Adlung R.(2005) ,"Public Services and the GATS" WTO ERSD Working Paper ERSD-(2005)-03July, 2005
3. Adlung R. and Carzaniga A., "Mfn Exemptions under the General Agreement on Trade In-services: Grandfathers Striving for Immortality? JIEL, 1–36 2009
4. Adlung, and Carzaniga (2001), Health services under the General Agreement on Trade in services, Bulletin of the World Health Organization, Vol. 79, No. 4, pp. 352-364
5. Caines K and Lush L.,(2004) Impact of public-private partnerships addressing access to pharmaceuticals in selected low and middle income countries: a synthesis report from studies in Botswana, Sri Lanka, Uganda and Zambia Publisher: Initiative on Public-Private Partnerships for Health, 2004
6. Blouin C., Drager N., and David P. Fidler D., (2008) " Trade in Health Services and the GAT" in A Handbook of International Trade in Services, A Mattoo et.al eds, OUP 2008;
7. Bruce Siegel, et al David Peters, Sheku Kamara, Health Reform in Africa: Lessons from Sierra Leone, World Bank Discussion Paper, forthcoming; also Staff Appraisal Report No. 13947-SL). (1997)
8. Bernstein M., & Sessions M. (2007) ",A trickle or a flood: commitments and disbursement for HIV/AIDS from the Global Fund, PEPFAR, and the World Bank's Multi-Country AIDS Program (MAP)" Publisher: Centre for Global Development, USA, 2007
9. Conway S., Harmer A., Spicer N., International Health Partnership: 2008 External review; Publisher: London School of Hygiene and Tropical Medicine (LSHTM): (2008 IHP Review)
10. David F.,(2004), Legal Review of the General Agreement on Trade in Services (GATS) from a Health Policy Perspective, WHO: Globalization, Trade and Health Working Papers Series, Geneva
11. Harford T., *et.al* "Private Finance Are private Loans and Charitable giving Replacing Aid?" Public Policy for the Private Sector; World Bank Group, April 2005 Note No. 290
12. Krajewski, M., (2003), Public Services and Trade Liberalization: Mapping the Legal Framework, Journal of International Economic Law, Vol. 6, No. 2, pp. 341-367
13. Lang A. " The GATS and regulatory autonomy: The case study of social regulation of the water industry" JIEL 7 (4) p 813 (2004)
14. Lang A., (2007) "Rethinking trade and human rights" in Tulane Journal of International and comparative law 336-206 p.345-6
15. Lamy Pascal (2008) "Access to medicines has been improved" The 11th Annual International Generic Pharmaceutical Alliance Conference — Geneva 9 December 2008 www.wto.org
16. Micklewright J., & Wright A., " Private Donations for International development" in New Sources of development Financing, Atkinson A. (ed) OUP 2005
17. Matthews, D 'TRIPS Flexibilities and Access to Medicines in Developing Countries: the Problem with Technical Assistance and Free Trade Agreements', (2005) EIPR 420
18. Marek T, Yamamoto C., and Ruster J., ; "Private Health: Policy and Regulatory Options for Private Participation" The World Bank Group June (2003) Note No. 2
19. McCreevy C., "Public-Private Partnerships – Options to ensure effective competition" PPP Global Summit – The 6th Annual Government-Industry Forum on Public Private-Partnership Copenhagen, 17 November (2005)
20. Nkhoma W., Regional Focal Point, WHO/AFRO "Public-Private Partnerships Form Tb Control In The African Region: Progress And Future Plans" Fifth meeting of the subgroup on Public Private Mix for TB care and control (Cairo, Egypt, 3-5 June 2008)
21. Smith, R., Blouin C., Drager N., and David P. Fidler D., (2008) "Trade in Health Services and the GAT" in A Handbook of International Trade in Services, A Mattoo *et.al* eds, OUP (2008)
22. Taylor R., and Blair S., "Public Hospitals: Options for Reform through Public-Private Partnerships" In Public Policy for the Private Sector; The World Bank Group January 2002 Note No. 241,
23. Tuosto C., 'The TRIPS Council Decision of August 30, 2003 on the Import of Pharmaceuticals under Compulsory Licences, (2004) EIPR 542,
24. Starling; M. Brugha R.; Walt; G... Heaton; A. Keith R; "New products into old systems: the Global Alliance for Vaccines and Immunization (GAVI) from a country perspective" Publisher: Save the Children Fund , 2002
25. UNICEF/WHO Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September (1978) para.6
26. United Nations Secretariat; "Public-Private Partnerships: The Enabling Environment For Development" Group Of Experts On The United Nations Programme On Public Administration And Finance Thirteenth Meeting 27 May-4 June 1997