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The World Health Organization and Global Public-Private Health Partnerships: In Search of 'Good' Global Health Governance

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THE PAST DECADE HAS WITNESSED DRAMATIC CHANGES in international cooperation through the United Nations and its organizations. Two interrelated trends stand out. First, as a function of globalization—defined as the accelerated diffusion of capital, traded goods, people, ideas, etc. across increasingly porous national boundaries—it is progressively more evident that a variety of challenges cannot be met efficiently at the national level, but require additional collective international, if not global, approaches (Kaul et al., 1999). Moreover, the ascendancy of organized capital over the power of the nation-state adds impetus to the need for intergovernmental cooperation. It has been argued that “short of a backlash against globalization, states will have little choice but to pool their sovereignty to exercise public power in a global environment now mostly shaped by private actors” (Reinicke & Witte, 1999). Consequently, globalization has highlighted the need for strengthened international cooperation and has resulted in significant discussion of reform within existing multilateral institutions, as well as the establishment of new ones with distinctive characteristics—for example, a World Trade Organization lying outside of the UN system that can exercise unprecedented and binding authority over its member states.

A second significant trend in international cooperation within the United Nations involves a shift from vertical representation to horizontal participation (Walt, 2000). Vertical representation describes a hierarchical, bureaucratic relationship between the state and its representation in the international organizations that make up the UN. Representation through this process provides, at least in theory, both a form of democracy and accountability (i.e., citizens represented through member states, and member states represented in decision-making

bodies, with decision-making bodies responsible to member states). Horizontal participation is more typical of the network society, in which states and non-state organizations, including the UN and private for-profit organizations, form less hierarchical and less bureaucratic interorganizational relationships. Global public-private partnerships (GPPPs) provide a form of interorganizational networking.

While there is, as yet, relatively little experience in determining how well these horizontal public-private partnerships work, it is clear that, in addition to their many potential benefits, they also pose a variety of potential challenges and threats in relation to international cooperation in health. The purpose of the United Nations, at the point of its establishment, was to further peaceful and cooperative relations among states. As one of its specialized agencies, the World Health Organization's role was to coordinate activities in health against a very broad constitutional mandate that saw health as a fundamental right and WHO's main objective as "the attainment by all peoples of the highest possible level of health" (WHO, 1946). An international civil service was established to provide support to countries and actions to advance this mandate. While the UN and WHO have always been constrained in their ability to achieve these lofty goals, and although we acknowledge significant weaknesses in many UN organizations, we nevertheless argue that the UN plays critical functions with respect to global health, among other things. Our concern is that horizontal participation, as evidenced in the growth of public-private partnerships at the global level, will further fragment international cooperation in health and undermine UN aims for cooperation and equity among states.

Our chapter begins with a short discussion of the meaning of partnership. We then describe the context in which public-private partnerships have emerged, drawing particular attention to the shift from "international" to "global" governance in the health as well as other sectors. Thereafter, we enumerate the interests that private and public actors pursue in relation to partnership, as these carry important consequences for the impact of GPPPs for international cooperation in health. We review the critical functions performed by the UN in relation to health and argue that these are made possible by a number of facilitating attributes which characterize UN organizations such as WHO. The manner in which partnerships with the for-profit sector may impinge, both positively and negatively, upon these facilitating attributes is explored. The chapter concludes that more care needs to be exercised in relation to preserving these important functions and attributes as partnerships proliferate. Although our primary interest is with health partnerships

and, consequently, WHO, we make an attempt to situate our discussion in a broader context and include examples that involve other UN organizations.

Defining Partnerships

Elsewhere we have described how the conceptual understanding of partnership has evolved over the past few decades (Buse & Walt, 2000a). In relation to development cooperation, the term was most frequently employed to describe aspirational relationships between official donor agencies and recipient ministerial bodies in developing countries. Today, a profusion of interpretations surround the term. We submit that the notion of partnership has become a cognitive device that groups similar things and thereby permits recognition and communication. However, when subjected to scrutiny, it becomes apparent that the notion of partnership is imbued with very different characteristics in different contexts. Although partnering (and the term *partnership*) clearly implies a tendency toward collaboration, it is also used to describe a wide range of relationships and activities. Consequently, there is the risk that the term often obscures more than it reveals. To assess the impact of partnerships on international cooperation for health and to judge under which circumstances partnerships are likely to be suitable and effective or what rules of engagement should guide partners' activities, we need greater specificity with respect to our object of analysis.

For this discussion, we employ a narrow and specific definition of a global public-private partnership for health. Health GPPPs are collaborative relationships that transcend national boundaries and bring together at least three parties—among them a corporation and/or industry association and an intergovernmental organization—so as to achieve a shared health-creating goal on the basis of a mutually agreed and explicitly defined division of labor (adapted from Buse & Walt, 2000a). While other parties, such as civil society organizations and private foundations, are often also critical partners in GPPPs, here our unit of analysis comprises for-profit and intergovernmental organizations.

Context

Globalization provides the defining contextual shift marking the widespread emergence of global public-private partnership. As noted above, international cooperation is affected in two major ways by increased global integration. First, globalization circumscribes some functional sovereignty of the nation-state and thereby reinforces recognition of the need for multilateral cooperation for

solutions to common problems (Kaul et al., 1999). Second, globalization, particularly through advances in communication technologies, facilitates horizontal and network-oriented approaches to governance (Reinicke, 1998). Consequently, multilateral cooperation has increasingly and purposefully looked toward the potential for public-private collaboration. For example, in his 1999 address to the annual meeting of the World Economic Forum, UN Secretary-General Kofi Annan reflected that “the United Nations once dealt only with governments. By now we know that peace and prosperity cannot be achieved without partnerships involving governments, international organizations, the business community, and civil society” (Annan, 1999). Reflecting Annan’s observations on the UN and relating these to the concept of governance, Mark Malloch Brown, administrator of the United Nations Development Program (UNDP), wrote in the foreword to the 1999 Human Development Report:

We are seeing the emergence of a new, much less formal structure of global governance, where governments and partners in civil society, the private sector, and others are forming functional coalitions across geographic borders and traditional political lines to move public policy in ways that meet the aspirations of a global citizenry. . . . These coalitions use the convening power and the consensus-building, standard-setting, and implementing roles of the United Nations, the Bretton Woods institutions, and international organizations, but their key strength is that they are bigger than any of us and give new expression to the UN Charter “We, the peoples.” (UNDP, 1999)

In so far as global governance involves the formal and informal “institutions and organizations through which the rules and norms governing world order are (or are not) made and sustained” (Held et al., 1999), Malloch Brown is correct in viewing partnership not solely as a reflection of globalization, but as a response to its processes as well. This is particularly the case where new principles, norms, and standards are elaborated within the framework of partnerships.

The emergence of GPPPs can be traced to a number of additional dynamics that marked the 1990s. First, the 1990s were characterized by an *ideological shift* from ‘freeing’ to ‘modifying’ the market. While many claim that “the age of medicine as a pure public service is over” (*The Economist*, 1998), most advocates of free markets have moderated their position to acknowledge a role for the public agencies, particularly in the health sector where markets are often not efficient and make equity difficult to achieve (Mills, 1997). This ideological shift is not based solely on economic philosophy but also on changes to the prevailing

sociopolitical orthodoxy—as noted above, increasingly a variety of stakeholders, including private sector representatives, are believed to have a legitimate say in public policymaking (Giddens, 1998).

Another contextual shift that fuelled the rise of GPPPs involved the growing *disillusion with the UN* and its organizations. Concerns about the effectiveness of the UN, including increasing evidence of overlapping mandates and interagency competition, led directly towards establishing partnerships to deal with specific and limited issues. Partnerships that are housed outside of the UN bureaucracy are viewed as a way of getting things done, and where industry is involved, getting things done efficiently. In relation to the Medicines for Malaria Venture (a public-private drug research partnership), for example, it was agreed that “the organization should run as a not-for-profit-business and be based on operational paradigms of industry, not the public sector” (Ridley et al., 1999). It has been suggested that the UN may see the benefits of industry partnership as ‘relegitimizing’ the UN and thereby enabling it to regain a more central position in global policymaking. For example, the Corporate Europe Observatory argues that “working with the International Chamber of Commerce diversifies the UN’s image, which in some countries, including the United States, is not ideal” (CEO, 1998).

Negative perceptions of UN effectiveness, among other things, have provided *financial impetus for partnerships* in that donors have imposed a policy of zero real growth in UN budgets and shifted toward supplementary (i.e., voluntary and ear-marked) funding. These funding trends have made GPPPs attractive (and perhaps necessary) to the UN. Resources provided by the private sector “are more than welcome; they are necessary” (Beigbeder, 1996). Beyond the commercial sector, important new sources of funding for UN partnerships are those from the new philanthropists (i.e., Bill Gates, George Soros, and Ted Turner).

The re-emergence in some quarters of a broader approach to public health (McKinlay & Marceau, 2000) may have also provided more fertile ground for GPPPs. Increasing recognition of the multifactorial determinants of health furthered the view that the *health agenda is so large that no single sector or organization can tackle it alone*. Emerging health problems required a range of responses beyond the capacity of the public or private sectors working alone, and therefore bridges needed to be built between sectors (Harrison & Lederberg, 1997).

The last point relates to a new appreciation and explicit understanding of how the actions of one sector affect the ability of the other sector to achieve its goals and how partnership can result in win-win interactions among private and public actors. There was, for example, an “honest recognition by the public sector” of the

“unique, unrivalled monopoly” of the pharmaceutical industry in drug and vaccine development: “They own the ball. If you want to play, you must play with them” (Lucas, personal communication, July 13, 1999). Batson (1998) demonstrated how the ability of the public sector to achieve universal immunization coverage is “inextricably linked” with the decisions and behavior of the vaccine-pharmaceutical industry and, conversely, how the behavior of industry with respect to research and development (R&D) into new vaccines is conditioned by the signals sent by the major public sector players. Batson argues, for example, that UNICEF’s centralized procurement (based on lowest-bid purchasing policies) of developing countries’ vaccines for the Expanded Program on Immunization ensured low prices but also sent signals that the public sector was not interested in encouraging pharmaceutical companies to invest in R&D for new vaccines which might benefit poor countries. More recently, one condition set by five major research pharmaceutical companies, as they forged a partnership with a number of UN organizations on access to AIDS medications, was that the public sector organizations commit themselves to strengthened intellectual property protection as a recognition of the significant investment these companies had made in product R&D (Gellman, 2000).

Changing markets and technology have heightened this appreciation of interdependence. In particular, new developments in biotechnology are making drug and vaccine discovery and development increasingly expensive, as are changes in the sphere of intellectual property rights. Concomitantly, extensive consolidation of the pharmaceutical industry has led to greater competition within companies, thus increasing the opportunity costs associated with investment in tropical diseases. These changes have led some health advocates to begin to explore ways in which public and private decision makers could work together to overcome market failures so as to develop and make available health promoting goods at a cost developing countries could afford, while minimizing the risk and guaranteeing a return to the private sector. Economic tools that reduce the costs of R&D, called ‘push’ factors, and those that address the lack of effective markets, termed ‘pull’ factors, are at the center of many health GPPPs (e.g., the International AIDS Vaccine Initiative, the Global Alliance for TB Drug Development, the Malaria Vaccine Initiative, etc.).

Changes in business-UN relations, as expressed by the formation of GPPPs, may also reflect the impact of globalization on the *structure of the global economy* (and within various industries) and on ways of doing business. In particular, three

possibly interrelated elements stand out. First, as noted above, transnational corporations have become the lynchpins of the world economy; the globalization of production has entrenched the power of organized corporate capital vis-à-vis state power (Held et al., 1999). This has undoubtedly emboldened corporations to demand a voice in intergovernmental decision-making, for example in the WTO and WHO. Second, increasing concentration empowers individual megacompanies in relation to both state and intergovernmental organizations, but also increases the possibilities for industry-wide association and organization (Myteka & Delappierre, 1999). Consequently, we have seen a rise in self-organization and private-sector-influenced regulation at the global level (Cutler et al., 1999). Third, there have been changes in the form of business organization. It has been argued that globalization is fuelling corporate alliances (and may, indeed be replacing mergers). It is speculated, for example, that whereas “the average large company, which had no alliances a decade ago, now has in excess of 30” (*Business Week*, 1999). These are love affairs, rather than marriages: competitors in one market can collaborate in others, and it is natural that the commercial world extends this form of organization to its relations with governmental entities.

Finally, the trend towards global public-private partnerships may be related to the change in public attitudes and the growing response of the private sector to concerns and vocal demands for *corporate responsibility and accountability*. Corporations themselves have realized their need to take into account broader responsibilities to society (Control Risks Group, 1997). This recognition has been stimulated by the strength of consumer, environmentalist, and other civil society group actions in industrialized countries, which have challenged international companies’ policies in a number of spheres and won considerable concessions (Wapner, 1995). GPPPs offer the possibility to improve corporate image. One company executive explained that public pressure was of highest consideration in terms of why his company sought partnerships with the public health sector (Auty, 1999). The positive experience of Merck’s donation of Mectizan (ivermectin) to onchocerciasis control programs in a number of endemic countries played an extremely important role in stimulating further ‘pharmaco-philanthropy’ (Wehrein, 1999).

Partner Interests in Global Public-Private Partnerships Differ

The specific interests that each party to a particular partnership pursues, the extent to which the party seeks to realize those interests through the partnership,

as well as its relative influence within the partnership arrangement will have some bearing on the effectiveness and outcomes of the partnership activity, but may equally play some transformative role within each partner organization. Here we enumerate some of the interests pursued by the private for-profit sector and United Nations (and WHO) through partnership generally before analyzing how the pursuit of these interests may alter characteristics of the UN. In the ensuing discussion, we have made generalizations about both the UN and the private sector. In practice, neither sector is comprised of homogeneous entities (nor indeed are GPPPs). There is a great diversity in size, competence, and efficiency among UN and for-profit organizations. Some divisions of UN bodies have been charged with malpractice, while firms are differentiated, among other things, by their willingness to comply with the rule of law and their interest in philanthropy and partnership. Moreover, private firms are also not solely driven by short-term economic imperatives to maximize profits. They may singly or collectively construct a variety of organizational arrangements that structure their own and others' behavior with a view to longer-term interests, and GPPPs provide one vehicle for so doing.

Private Interests in Global Public-Private Partnerships

Incorporating industry interests in global governance

We want neither to be the secret girlfriend of the WTO nor should the ICC have to enter the World Trade Organization through the servant's entrance.

Helmut Maucher (1997), ICC President

As the processes of globalization intensified during the 1990s, industry came to recognize the potential benefits of alliances with the United Nations. For example, according to Maria Cattai, secretary general of International Chamber of Commerce (ICC), "Business believes that the rules of the game for the market economy, previously laid down almost exclusively by national governments, must be applied globally if they are to be effective. For that global framework of rules, business looks to the United Nations and its agencies" (Cattai, 1998a). Maucher (1998) supports this position, arguing that "in this process of modernization and globalization of rules, ICC is making a positive contribution, both as an advisor and through its own standard setting. . . . Broader efforts should now follow in order to foster rules-based freedom for business, with the WTO assuming a key role." While the ICC conceded the need for additional authority for

intergovernmental organizations, this was “with the proviso that they must pay closer attention to the contribution of business.” The ICC was, however, concerned that the “power of world business” has been “poorly . . . organized on the international level to make its voice heard” (quoted in CEO, 1998). Consequently, the ICC established, in its words, a “systematic dialogue with the United Nations” in an effort to redress this perceived threat to its interests (Cattaui, 1998b).

Industry has embarked upon a multi-pronged strategy to influence UN decision making. For example, in June 1997 the executive director of the World Business Council on Sustainable Development (WBCSD) cohosted a high-level public-private sector meeting with the president of the UN General Assembly to “examine steps toward establishing terms of reference for business sector participation in the policy setting process of the UN and partnering in the uses of UN development assistance funds” (Korten, 1997).¹ The meeting concluded that “a framework” for corporate involvement in UN decision making be worked out under the auspices of the UN Commission on Sustainable Development (Korten, 1997). The ICC also conceived the Geneva Business Partnership. Established in September 1998, the Partnership enabled 450 business leaders to meet with representatives of international organizations so as to determine “how to establish global rules for an ordered liberalism” (CEO, 1998). One outcome of the industry effort is a joint UN-ICC statement on common interests which includes a call to “intensify the search for partnerships” (United Nations, 1998). Interaction among the commercial and public sectors, while neither new nor ipso facto ‘partnership,’ reflects the increased intensity, extent, and purpose of growing private-sector interests in public-sector decision making.

GPPPs and emerging market penetration

Corporate success will be increasingly dependent on harnessing these new markets and production opportunities.

UNDP, 1998

Globalization is perhaps most advanced in the economic sphere. Nonetheless, according to the World Bank, more people live in poverty than ever before. The United Nations portrays poverty as a “downside of globalization” but also suggests that poverty is both a threat and an opportunity to industry interests. It is a threat in the sense that mass poverty could lead to destabilization, thereby jeopardizing the smooth functioning of the market, and an opportunity in terms

of the poor being a potential market-in-waiting. Companies such as Dupont, Unilever and Johnson and Johnson are experimenting with rural poor markets as they see most growth potential at the bottom of the pyramid (Slavin, 2001). Market creation is the explicit goal of a number of UN-industry partnerships. For example, through the Global Sustainable Development Facility (GSDF), leading corporations and UNDP aimed to include two billion new people in the global market economy by the year 2020 (UNDP, 1998). The GSDF was to be established as a separate legal entity outside the UN system that would be “primarily governed by participating corporations and will benefit from the advice and support of the UNDP through a special relationship” (UNDP, 1998). The GSDF was addressed, among other things, to “developing products and services adapted to the emerging markets of the poor” (UNDP, 1998). Despite early interest and participation of numerous corporations, UNDP aborted the initiative due to the controversy that it provoked (New, 2000).

Thus public-private partnerships are sometimes proposed as priming-the-pump of economic globalization in those areas where the market is not well enmeshed in the global economy, but also as an opportunity for individual firms to penetrate specific markets. As the president of the medical systems unit of Becton Dickinson & Co. has remarked, “Of course we want to help eradicate neonatal tetanus, but we also want to stimulate the use of non-reusable injection devices, and to build relationships with ministries of health that might buy other products from us as their economies develop” (Deutsch, 1999).

GPPPs and corporate citizenship

Kofi Annan has warned that because “globalization is under intense pressure . . . and business is in the line of fire . . . business must be seen to be committed to global corporate citizenship” (Annan, 1999). Emerging public-private relationships often move beyond the simple philanthropy (gift giving) of the past and can be differentiated by a range of motivations including corporate responsibility (obligation-oriented), corporate citizenship (rights and responsibilities) and, as noted above, strategic gain (Waddell, 1999). Collaboration is in part due to the fact that the commercial sector has been increasingly challenged to show greater social responsibility, to invest in the well being of populations, to adhere to global labor and environmental standards, and to invest in research and development that benefits the poorest. Debate surrounding the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)

is illustrative of the manner in which GPPPs provide industry an opportunity to demonstrate its corporate citizenship. Concerns have been raised that implementation of the TRIPS Agreement will increase the costs and, thereby, limit access to essential drugs in developing countries (pursuant to strengthened patent protection on process and product and controls on the manufacturing and export/import of generic drugs) (Velasquez & Boulet, 1999). Industry acknowledges that access to medicines in poorer countries is an issue but suggests that the “long-term donation programs instituted by pharmaceutical companies for such debilitating diseases as trachoma, filariasis and river blindness” (i.e., high profile GPPPs) provide a means to redress the access problem (Bale, 1999). Similarly, UN-industry partnerships are also seen as a solution to contentious issues arising out of the implementation of TRIPS, such as compulsory licensing (i.e., licenses issued by governments on public health grounds, authorizing third parties to manufacture a patented product without the consent of the patent holder). Some GPPPs have been promoted on the grounds of offering an alternative to compulsory licenses to protect the poor. For example, the Bristol-Myers Squibb’s partnership with UNAIDS and a variety of actors in southern Africa, known as ‘Bridging the Gap,’ has been cited as one way forward in lieu of compulsory licensing (*Chicago Tribune*, 1999). Furthermore, as mentioned above, a number of pharmaceutical companies have entered into a partnership to lower their prices for AIDS drugs for developing countries in an effort both to forestall the granting of compulsory licenses and to react to negative publicity (Gellman, 2000).

United Nations interests in global public-private partnerships

The interests that the United Nations and its organizations pursue through participation in GPPPs have already been alluded to. First, there is the financial imperative. Budgets throughout the system have been frozen and/or reduced. Partnership with the private sector enables the UN system to leverage its own resources and advice and to access new resources that enable it to fulfill its mandate. This carries weighty implications for the power and influence that the UN organizations bring to various partnership arrangements. Second, the UN has increasingly accepted the prevailing orthodoxy that suggests that partnership is the way to overcome market and government failure. It therefore has an interest in experimenting with partnership strategies and mechanisms that might overcome these failures to produce global public goods. Finally, in recognition of the

rise of corporate power and influence, partnership allows the UN to maintain a voice in arrangements of global governance.

WHO's enthusiasm for partnership mirrors that of the UN. Nonetheless, WHO's approach is distinct because of its explicit focus on health—the specific health goals pursued by the organization as well as the underlying ethical values that support its mission (Buse, 2001). WHO tends to enter into partnerships which have well-defined and specific health outcomes such as those that are disease or risk-factor oriented. Through partnership with the commercial sector, WHO seeks (in addition to the broad motivations described above) to achieve a range of objectives that include:

- To encourage industry to adopt and abide by the universal health principles established in Health For All
- To facilitate universal delivery and access to existing essential drugs and health services
- To accelerate research and development of vaccines, diagnostics, and drugs for neglected diseases
- To prevent premature mortality, morbidity, and disability
- To encourage industry to develop 'healthier' products in ways that are less harmful to workers and the environment
- To integrate health in all sectors for sustainable development
- To absorb and acquire knowledge and expertise from the private sector
- To enhance the organization's image among constituencies hostile to the UN

Functions and Attributes of the United Nations— What Implications Partnership?

The preceding discussion suggests that public and private actors pursue a variety of interests through partnership, and that these may affect the particular objectives of any individual partnership. In that the partnering process may be transformative, it is arguable that the pursuit of the aforementioned interests may influence the work of either sector. Such influence may be positive or negative. Partnering, for example, may imbue the UN with entrepreneurial talent and business culture which some might argue may thereby improve its efficiency. Similarly, the business community may adopt norms and values espoused by the UN in relation to workers' rights or occupational health, for example. Alternatively, less beneficial outcomes from partnering might obtain. The values and norms of the UN might be

captured or diluted, and its decision-making structures subject to commercial considerations. Business may become mired in public-sector bureaucratic procedures.

Although it is still unclear exactly how public-private partnerships between the United Nations and the for-profit sector will influence the work of the UN, this section explores some of the potential changes in relation to public health. The section is organized around a framework that proposes that multilateral organizations such as WHO play four critical functions with respect to global health, enabled, to varying degrees, by a variety of facilitating attributes. The manner in which partnership impinges upon these attributes constitutes the substance of this section (summarized in table 7.1). In presenting this idealized model of the functions of WHO, we are not suggesting that the organization has fulfilled them consistently in an effective and efficient manner. We fully acknowledge that the UN in general and WHO in particular have a variety of shortcomings that have inhibited them from fulfilling these functions (Godlee, 1994; Walt, 1996). However, we believe that every effort should be made to enable the UN to fulfill its potential and feel that attempts at reform of the organization of the past decade have been similarly motivated by such concern. We are also concerned that without due attention, global public-private partnerships may further compound the organization's difficulties.

GPPPs and normative frameworks

The United Nations' so-called Charter Model aims to organize world affairs according to the principle, among others, that nation-states are bound to a series of 'universal' norms and values (Cassese, 1986). The UN plays a prominent role in providing a platform for the discussion, negotiation, and promotion of these norms and values.

This role, however, is not without tension. Norms and values are culturally based and regularly contested. For example, in societies characterized by goals of universality and equity, based on principles of risk pooling and resource redistribution, citizens have different expectations of the state than do those in societies driven by individualism and markets, with collective response often limited to instances of market failure. Perhaps because of these underlying differences in norms and values, differences also exist in the perception of the legitimacy of close connections between the corporate world and the public sector. In European societies organized along principles of solidarity, for example, there has been greater separation and less interaction between public and private sectors

Table 7.1: Functions and attributes of the World Health Organization and how these might change through partnerships with the private sector

CRITICAL AND UNIQUE FUNCTIONS	ENABLING ATTRIBUTES	POSITIVE INFLUENCE OF PARTNERSHIP	NEGATIVE INFLUENCE OF PARTNERSHIP
WHO acts as the world's health conscience (e.g., human rights and equity), providing a moral framework and agenda for health.	Moral authority deriving from near universal membership. Constitution specifies concern for health of all peoples and special attention to needs of poor.	Partnerships may provide resources that enable WHO to promote its moral framework more forcefully. Partnerships may encourage for-profit entities to support WHO mission and values.	Function and attributes potentially undermined through value diffusion by more powerful private-sector interests.
Establishing global norms and standards	Legitimacy deriving from universality (particularly representation of poor countries and population groups), specialization, expert technical networks, and associated attributes of impartiality and neutrality.	Private sector may be more willing to abide by standards and norms elaborated through multilateral means if it has a voice in articulating them through its participation in partnerships.	Function potentially eroded if normative activities are shifted to GPPP expert committees where particularistic private interests may prevail.
Promotion and protection of the global commons (including creation of transnational public goods such as R&D capacity, information dissemination, and control of transnational externalities such as environmental risks, spread of pathogens, trade in illegal substances).	Mobilizing collective state action and resources through convening power and consensus building.	Enhanced for particular goods through access to additional resources from non-state actors. Potential to bring new resources into the control process. Potential to involve those private actors whose activities have the greatest impact on transnational externalities.	Depends on how private partner's interests are impacted by the creation of any good or control of any bad. Where conflicts of interest arise, private partners may seek to subordinate social and health standards to profit objectives thereby thwarting WHO objectives. May also entail shift to industry self-regulation.
Supportive cooperation at country level (particularly for unfashionable activities such as training and health systems support).	Reliant on members dues and bilateral (and other) donations to fulfill its mandate.	Potential to raise additional resources and engage additional partners to support health sector development in countries in greatest need.	EBF funding for country level activities may be reduced as 'profitable' activities hived off to GPPPs while difficult activities left with WHO. May lead to intercountry inequity as GPPPs focus on countries.

than in the United States. Thus the scope and extent of corporate philanthropy has differed. In Europe corporate philanthropy has a long tradition, but it has been low profile and relatively limited. In the United States corporate philanthropy has had a strong institutional presence and made significant investments in community and international development efforts.

Public and private sectors, similar to societies, social groups, and individuals, bring a number of different values to partnerships. At the one end of the continuum are the values of the UN: “Our main stock in trade . . . is to promote values: the universal values of equality, tolerance, freedom, and justice that are found in the UN Charter” (Annan, 1999). Also at this end of the continuum is WHO, with its concern for the health of the marginalized and dispossessed, and its claim to be the world’s health conscience. WHO’s values flow from its constitutional mandate, while its claims to promoting universally held values derive from its wide membership (the majority of nation-states).

At the other end of the continuum are the ‘bottom line’ values and interests to maximize profits so as to increase shareholder value that are reflected in company policies, although such values are increasingly framed within explicit goals of social responsibility. For example, the Royal Dutch Shell Group sees their role “not just as commercial operators, but as investors in communities, in people, in societies around the world.” Irrespective of one’s interpretation of such rhetoric, two caveats are in order. First, as stated above, the corporate sector is diverse, and among the socially responsible business entities are those whose activities have been highly criticized for pursuing profits by aggressive marketing or poor labor practices. Second, despite encouraging signs of enhanced corporate social responsibility, the primary responsibility of any commercial enterprise remains a fiduciary one to its owners.

There has been, therefore, great debate over whether or not—despite shared partnership goals—private and public interests are mutually compatible. Several mechanisms have been identified through which profit maximization may undermine the goal of better health (Hancock, 1998). Within partnerships, the question arises as to whether or not private sector values will ultimately dominate as the UN and industry move closer towards jointly defining their goals through GPPPs—and as the values of the weaker partner are captured by the more powerful. It is possible that WHO’s emphasis on and advocacy for the marginalized and the poor will be displaced as resource-rich partnerships dictate organizational priorities and strategies. It has been suggested, for example, that

WHO's involvement in the Global Alliance for Vaccines and Immunizations (GAVI) has derailed the organization's commitment to equity in relation to the goal of universal vaccination with traditional vaccines as it joins with its partners in bringing 'new' vaccines to the relatively less hard to reach (Hardon, 2001). Similarly, it was argued that recent WHO-convened deliberations on breast-feeding were subject to censorship due, it is asserted, to considerations of the sensibilities of WHO's new commercial constituencies (Ferryman, 2000).

Alternatively, is it possible to ensure that core public and private identities and values are preserved as partnerships limit themselves to specific win-win situations? This will depend first on the selection of private partners. Hancock urges "sober second thoughts" regarding the suitability of the pharmaceutical industry as a partner for WHO, at least in terms of health promotion, because of "perceived or actual conflict of interests" (1998). Second, it will depend on the rules of engagement. In practice, given the financial imperatives that sometimes motivate UN organizations to enter into partnerships with the private sector (i.e., the stagnation of funding referred to above), they may find it difficult to refuse corporate offers that do not comply with internal guidelines.

Optimistically, many believe that increased interaction through partnership will be transformative in a more positive manner. In particular, that partnership will promote more socially responsible business entities and practices, which actively promote and uphold the values and norms enshrined within the UN Charter and subsequent conventions. And that some of the strategic, outcome-oriented methods of the private sector might be absorbed into the UN.

Establishing global norms and standards

The United Nations plays an important role in the area of developing normative standards governing activities in all spheres of social life—from shipping lanes to postal services. In the health sector, WHO has a mandate to develop standards (and international treaty law) in five areas: quarantine requirements; nomenclatures in respect to diseases, etc.; standards for diagnostics procedures; standards for safety, purity, and potencies of medications; and advertising, marketing, and labeling of health related goods. A series of attributes enable WHO to assume this role in global norm and standard setting, including relative legitimacy, technical competence and authority, impartiality, and neutrality. These attributes, which are in some ways interlinked, derive from and rest upon the governing arrangements of WHO. Partnerships with the commercial sector may entail

reform of these arrangements and therefore raise questions of how to preserve these crucial attributes upon which global norms and standards are developed, particularly those which sustain or promote the ethical values described above. In relation to independent norm and standard setting within WHO, critics charge that partnership may subject WHO to commercial influences. It is argued, for example, that its impartiality was jeopardized during the elaboration of the Guidelines for the Management of Hypertension as a result of the influence of a firm that stood to benefit from them (Woodman, 1999).

Legitimacy concerns the extent to which authority is considered valid by those affected by it. Legitimacy confers upon its holder a recognized right to establish norms and standards. It is fair to argue that most UN organizations derive some of their legitimacy from near universal membership in their governing bodies. For example, the World Health Assembly is currently attended by 191 member states, all of which have equal voting rights irrespective of size of financial contribution. In contrast, representation in global public-private partnerships is both narrower and more eclectic. No health GPPP can claim near universal membership of nation states (which would make it unwieldy in any event), but, more importantly, few partnerships include low-income country representation, not all of them include WHO on their governing boards and technical committees, and in some cases it would appear that the private sector representation is ad hoc and based on personal contacts.

In recognition of the limitations of representative legitimacy, the legitimacy of many GPPPs will depend largely on the expert committees that are established to advise them. Whereas the specialized agencies of the UN, such as WHO, rely on extensive networks of technical experts and have established means for selecting and operating expert groups, there are concerns that GPPP expert groups may be chosen from exclusive epistemic communities, may (due to funding) suffer from a lack of independence, and may have circumscribed powers (Buse & Walt, 2000b).² Although many analysts have drawn attention to the extent to which international agenda setting and formulation of policy is controlled by transnational policy elites (Haas, 1992), the implications of the increasing prominence of the private sector in policy networks on global standard setting has yet to receive much attention (Cutler et al., 1999). Sell's (1999) detailed account of the role of twelve CEOs of US firms in drafting the WTO TRIPS Agreement provides an exception.

Partnerships also raise difficult questions in relation to competence and appropriateness. WHO has a constitutional mandate to coordinate international

efforts in relation to health. This has always been a difficult task, one which will be made more difficult as the sector is further fragmented through the advent of numerous and sometimes competing partnerships and initiatives. By 2001, there were, for example, several partnerships focusing on malaria, on vaccinations, and on anti-retroviral drugs for HIV/AIDS. The strong emphasis on infectious diseases attracted attention and financial resources, putting other health issues into shadow and undermining any role WHO might have played in forging a coherent global agenda. Moreover, as global responsibility for specific health issues is transferred from WHO programs to GPPPs, there is some danger that WHO will fail to continue to establish expert groups on these issues so as not to duplicate the technical committees established under the aegis of the partnerships (whose membership is usually vetted by the corporate sponsors). This raises the specter of the erosion of WHO's normative function. Where the private sector assumes a greater voice through partnership in WHO technical discussions, will global standards and norms not begin to more closely reflect private interests, thereby jeopardizing their credibility? For example, if a malaria vaccine is developed under the sponsorship of the Medicines for Malaria Venture partnership, there may be a risk that process and product standards concerning any vaccines developed will be unnecessarily high, thus discriminating against low- and middle-income countries.

The global health commons

As noted in the introduction, the determinants of health as well as the means to address them are increasingly subject to transnational forces. It can, therefore, be argued that the imperative for nation-state collaboration to address problems of the global health commons is more compelling than ever. The promotion of global public goods (i.e., those which are nonexcludable, nonrival, and exhibit significant positive externalities), such as research and development on health, the generation and dissemination of knowledge, norms and regulatory standards, and the control of negative international externalities such as transborder spillover of environmental risks, drug resistance, etc., are therefore gaining increased attention. A central role for the United Nations has been proposed in relation to the protection and promotion of the global commons (Kaul et al., 1999). This role derives from its ability to convene a broad array of actors, develop consensus, and mobilize resources.

A number of GPPPs have been established to address problems of the global health commons (such as the Stop TB Initiative). Consequently, it can be argued

that the addition of private resources through GPPPs further enables collective international action on critical public health issues. Private resources may be provided to partnerships directly which aim to promote global public goods, or partnerships may encourage private behavior that minimizes negative transnational externalities or promotes positive transborder spillovers. The challenge remains, however, to establish systems for priority setting that are fair and just with respect to which public goods to produce and which externalities to control. At present this is decided in a somewhat ad hoc and opportunistic manner.

Supportive cooperation at the country level

In a world marked by increasing inequalities, the United Nations also plays a role of protecting the health of vulnerable populations and providing development support (e.g., capacity development) in low-income countries. While WHO shares this role with a host of other agencies, its aid need not be conditional upon political and economic objectives (as is often the case with bilateral aid) and can therefore be allocated according to objective measures of need—although this is patently not always the case (Michaud & Murray, 1994). The WHO is able to play this role as a function of the dues it receives from its members and it can allocate these resources according to nonpartisan criteria as a function of its relatively ‘apolitical’ nature. Public-private partnerships can enable the UN to further its work in poor countries and populations as demonstrated by the success of the African Program for Onchocerciasis Control to deliver drugs to the poorest Africans in the most remote settings.

On the negative side, those countries that do not benefit from partnerships might feel abandoned by the global community. And partnerships may increase inequities within societies: for example, the World Alliance for Community Health, which includes Rio Tinto, Placer Dome and other multinational corporations, aided by WHO, is helping companies develop a “business plan” for health, “to improve health of firms as well as ordinary people.” While potentially bringing better quality primary health services to workers and their families, such efforts may undermine universal health systems (*The Economist*, 1999). Worse yet, if activities that are in vogue are hived off to special partnerships, there is the potential that bilateral funds that might have been allocated to the UN may be redirected to GPPPs, thereby further imperiling the financial situation of the organizations, as well as undermining (or devaluing) government efforts, and possibly increasing inequity among countries.

There is also the danger that GPPPs focus on relatively narrow problems and solutions (drugs for malaria and TB, vaccines for HIV/AIDS) and pay insufficient attention to the strengthening of health service delivery systems, which are crucial if new proposals are to work. For example, Hardon (2001) has raised the concern that the Global Alliance on Vaccines and Immunization (GAVI) is focusing largely on the introduction of new vaccines to countries, while little attention and few funds have been allocated to making fragile health systems more effective. In such a situation, helping sustain health systems through training and support might be left to organizations such as WHO.

In summary, table 7.1 suggests that there are potential pros and cons of partnerships in relation to WHO. While partnerships may reinforce some of WHO's functions, the potential threats enumerated above in relation to the organization's mandate, the manner in which global norms and standards are established, and which global public goods and countries receive WHO support, suggest that some caution should be exercised in the partnering process. WHO performs very specific functions based on particular values, institutional characteristics, and decision-making processes. Uncritical support for poorly designed partnership initiatives may undermine WHO's functions and further fragment intergovernmental health cooperation. The extent to which a partnership may impinge upon the work of WHO will depend not only on the nature of the problems and resources available to address it, but also, to a great extent, on the institutional arrangements by which it is governed. These include the selection of partners, the composition of the governing bodies, balance of power among private and public parties, the mechanisms by which decisions are made, and the systems established to ensure accountability and transparency.

Partnerships and Governance

Governance can be defined as “the process whereby an organization or society steers itself” (Rosenau, 1995). Broadly speaking, governance comprises the systems of rules, norms, processes, and institutions through which power and decision making are exercised. Good governance is thought to be based upon: (1) representative legitimacy; (2) accountability; (3) competency and appropriateness; and (4) respect for due process (World Bank, 1994).

A number of challenges to good governance confront the UN as it enters into partnerships with the private, for-profit sector. For example, in relation to representative legitimacy, it would appear that GPPPs provide the commercial

sector and purposely selected (predominantly northern) scientists with improved access to decision making within the UN, which is not matched for recipient countries, not-for-profit agencies, southern scientists, and other marginalized groups. This carries significant risks and will have to be handled with caution: “Opening up participation to a broader group of non-state actors and NGOs . . . there is a risk that institutions will simply increase access to representatives of US-based and European-based groups and further skew institutional participation and accountability away from the broader, more universal set of members” (Woods, 1999, p. 57).

Accountability, which is broadly concerned with being held responsible for one’s actions, poses similar challenges. Public and private sectors have well-established mechanisms of accountability. In the private sector, management is accountable to the company’s shareholders. In the public sector, administrative structures report to political structures, which are accountable to the ruled through the contestability of political power. We argued above that accountability within the UN rested upon representation of member states in its governing bodies. However, accountability within public-private partnerships may be less straightforward, partly because of the distance between the global partners and the beneficiaries and the length of time for any impact to be felt. Moreover, actually holding a partner accountable presents difficult challenges, as they are autonomous entities. Presently, systems of sanctions do not appear to have developed to apply to negligent partners. In a number of GPPPs, accountability appears to be predominantly oriented towards the commercial sponsors—e.g., the Mectizan Donation Program (Frost & Reich, 1998)—whereas in others, the management group reports to a governing body whose members report back to their respective organizations—e.g., the International Trachoma Initiative (J. Cook, personal communication, May 20, 1999).

In relation to competence and appropriateness, we have described how partnerships may shift the locus of technical groups outside of the remit of the UN organizations and how, through this process, global norms and standards may tend to more closely reflect private interests. We may also witness a brain-drain from WHO to ‘competing’ partnership institutions, which could affect the organization’s capacity and technical authority. Due process, or the extent to which institutional regulations are observed, has yet to receive much attention in relation to the governance of GPPPs. Although WHO has developed provisional guidelines and a process for vetting partner companies, introduced conflict of

interest forms, and established other internal procedures, these have provoked controversy—even among members of its executive board (WHO, 2001). While transparency of decision making to the public will be essential, conflicts of interest may well arise, with information controlled or censored. At present, although many high profile partnerships host a website and produce annual reports, these contain surprisingly little information on the arrangements through which the partnerships are governed.

Conclusions

Globalization necessitates novel arrangements for health governance in which international organizations and nation-states, as well as global and local private, for-profit, and civil society organizations work together. GPPPs provide one such mechanism—and an apparently popular one. While GPPPs have great positive potential they also raise a number of challenges in relation to the United Nations system, especially regarding the potential for further fragmentation of international health cooperation. UN organizations are well aware of some of these potential problems. Although positive towards GPPPs, UNICEF's present executive director has warned, "it is dangerous to assume that the goals of the private sector are somehow synonymous with those of the United Nations, because they most emphatically are not" (Bellamy, 1999). WHO's provisional guidelines on involvement with the commercial sector reflect this and other concerns, particularly those dealing with real and perceived conflicts of interest (WHO, 1999). As these guidelines fall short on a number of counts (Buse, 2001), there are grounds for a wider debate on a regulatory framework that can differentiate between acceptable and unacceptable GPPPs by ensuring that the former meet specific minimum conditions. Accrediting GPPPs may allay concerns of critics while benefiting private sponsors of partnerships as well.

Falk (1999) reminds us that "there is little, or no, normative agency associated with this emergent world order: it is virtually designer-free, a partial dystopia that is being formed spontaneously, and in the process endangering some of the achievements of early phases of statist world order." Greater thought needs to be given to how the present patchwork of alliances and partnerships in health move towards a system of 'good global governance' without losing their energy and creativity. How far is it realistic to work towards a *global health governance network* that would build on existing organizations, common values, and agreed regimes (Kickbusch & Buse, 2000)? Although we are in a period of exploration and

experimentation, it is not too late to ensure that, within the patchwork, the critical functions and attributes of the World Health Organization elaborated in this chapter remain intact. More research and debate on how to safeguard these functions, establish criteria for acceptable partnerships, and design a legitimate oversight body will undoubtedly prove more challenging than bringing public and private actors together to act on neglected health concerns, but it will ultimately prove equally rewarding.

Notes

1. The WBCSD is a council of transnational corporations established to represent the interests of global corporations at the UN Conference on Environment and Development in Rio in 1992.
2. For example, the Technical Advisory Group of the International Trachoma Initiative was not consulted on the choice of recipient countries.

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