

# WHAT'S IN A NAME? - PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH

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## Abstract

*Tracing the evolution of health public-private partnerships (PPP) the paper argues that the partnership label covers a variety of only marginally related arrangements. While the UK health PPPs are relatively well-defined and based on a consistent if still disputed paradigm, elsewhere partnerships include highly diverse arrangements - with the so-called global PPPs having become important actors in international health policy and health financing in low-income countries.*

*The global PPPs include members in which the private sector plays a significant role. However, the general situation is that governments and charitable foundations provide the bulk of the funding and that a large share of the research is carried out by academic institutions rather than by the private, corporate sector.*

*The case is made for developing and using a standard protocol for future evaluations of global PPPs and for strengthening knowledge management regarding domestic, low-income country health PPPs in the shape of an international health PPP advisory service under the auspices of one of the multilateral institutions engaged in the issue.*

**Key words:** Public-private partnership; Global health; Innovative financing; International health policy; World Health Organization; Multilateral institutions; Aid effectiveness.

## Introduction

The exploration in this paper was motivated by a pervasiveness of references to public-private partnerships in health. The objective was to identify the cause of the concept's increasing inclusiveness and ambiguity and establish whether redefining and categorising it would facilitate appreciation of what PPPs are and how they function - and thereby edify the discourse.

## Methods

Envisaged as a qualitative review the study set out by charting the evolving semantic and thematic dimensions of the PPP concept. Searches were made using PubMed, Highwire and Google Scholar engines and applying gradually refined and proliferative profiles. Rather than an exhaustive scrutiny, the aspiration was to identify frequently referenced papers and other key

documents. Global public-private partnership websites were searched for key strategic documents. Searching Google elicited documentation from the so-called grey literature, i.e. technical reports, research papers etc. not generally accessible via bibliographic channels.

## Evolution of PPPs

The earliest relevant PubMed reference to public-private partnerships and health – from the US – dates back to the mid-1960's. However, until the late 80's less than an average of one paper annually was published on PPPs. In fact, judged by the diversity of these early papers it was not until the Thatcher era, and sustained and reinforced under Tony Blair's premiership in the UK, that the concept began to take on a commonly accepted meaning and specific practical manifestations.

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In the UK version, the PPP arose from the notion that the private sector was better than the public sector at doing certain things. Implicitly, by harnessing the entrepreneurship, management skills, efficiency, and financial resources of the private sector and bringing this to bear on the provision of services traditionally in the public domain, it was possible to achieve better value for money (Allen, 2001). Technological and financial innovation unquestionably contributed to the development and eventual success of the early PPPs in transport infrastructure ventures. Based on this experience PPPs were similarly introduced in the National Health Service (NHS) to make private capital available to, and liberate the creative potential of the private sector for the physical renewal and operation of, initially, hospitals but gradually also other health care assets. The central idea was to bring resources and creativity together with the aim of procuring more health than would otherwise have been possible. Whether, in fact, this objective has been realised remains, as far as can be ascertained, unevaluated, and the added value of PPPs in the NHS continues to be a topic of some debate.

Conversely, in the US PPPs began to emerge as vehicles for preventive community-based interventions against e.g. obesity, diabetes, poor nutrition, and smoking, from 2003 with the support from the Centers for Disease Control and Prevention's Steps Program (Easton, 2009).

From the late 1990's differently shaped and configured health PPPs started appearing. Thus, several international collaborative arrangements aimed at responding to developing countries' health problems were established involving the private and the public sector. These generally involve an industry partner, one or more multilateral agencies such as the WHO and the World Bank, charities, academia, and in several cases bilateral donor agencies. Some of these global public-private partnerships (GPPPs), named product-based GPPPs by Buse et al (2000), have as their objective to manage the development and/or delivery of pharmaceuticals or vaccines for specific disease entities, often to overcome a market failure, i.e. where the financial return would not allow recouping the (private) investment. Systems/issues-based GPPPs are either more broadly scoped or simply escape convenient classification.

The forerunner of a next generation of international health PPPs was the Roll Back Malaria (RBM) initiative, set up in 2000 by the WHO, jointly with other UN agencies and the World Bank, under the leadership of Dr. Gro Harlem Brundtland. Following

this, several other multilateral health PPPs materialised, thus the Stop TB Partnership, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and GAVI (The Global Alliance for Vaccines and Immunisation). With a higher profile and more broad-based strategies than the earlier arrangements, the new partnerships also generally comprise private and public sector stakeholders, such as bilateral donor agencies, private sector philanthropists, the financial community, multinational firms, research and technical institutes, and multilateral organisations. However, by comprising also developing countries as partners and inviting the participation of smaller private sector businesses and civil society organisations, these GPPPs effectively emerged and evolved as reflections of the process of globalisation in geographical, socio-economic and cultural terms. In 2008, the number of international PPPs was estimated to have reached 100 ventures (Widdus, 2005).

By the time the GPPPs were becoming features of the international health aid landscape, a realisation of the size of the private health sector in individual low- and middle-income countries began nourishing consideration of how better collaboration between the private and the public health sectors might be encouraged and formal arrangements for this established. This reflection was further encouraged by the advent of the Sector-Wide Approach (SWAp) which had emerged over the preceding years as a modality to coordinate and integrate external assistance for health with and in support of recipient country ownership of health policy, strategy, and financing.

Sizing up the reality as regards indigenous health PPPs in low- and middle-income countries is extremely difficult. Among 103 relevant publications 21, 18, and 7, respectively, concern Asian, African, Latin American country PPPs, while the scope of the remaining 57 publications is international without a particular country focus. A review of the country-focused publications reveals a lack of a universally accepted definition of PPP. In fact, in some instances it appears as if almost any type of collaboration between the two sectors is seen as a PPP, whether based on formal agreement or not, including in some cases state recognition of faith-based health care organisations. Classification by purpose of the referenced PPP papers found that half concerns single-disease/issue interventions (TB, malaria, onchocerciasis, or other), STD/AIDS/HIV, immunization, or family planning, while the diversity of the remaining half defies meaningful further sub-categorization. Some domestic PPPs are local extensions of GPPPs, implementing country-based activities on their behalf.

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The grey literature is not conducive to systematic analysis. Neither fine-tuning nor searching within searches brings the number or the topical alignment of hits to within analytically manageable range.

### **GPPPs' Scoreboard**

The scope and experience of both UK health and US preventive PPPs differ significantly from the global ones'. The amount of published information concerning domestic PPPs in developing countries precludes further study. Thus, the following relates almost solely to GPPPs.

#### *The Claims*

There is near-universal agreement that the architecture of international health has undergone dramatic change and that the resources available to support health services to the world's poor have increased substantially as a result of the GPPPs.

Thus, the product development partnerships (henceforth PDPs (Matlin et al., 2008)) successfully bring participants together from all sectors to maximize the skills and resources to tackle complex issues of drug development and distribution. As a result of the PDPs innovative systems and creative processes - said to challenge governments, industry, academia and non-profit organizations to face urgent public health issues - new products, albeit developed from existing compounds, are now available.

Equally, an assessment of the so-called Global Health Partnerships (GHPs), essentially the 'second-generation' GPPPs, asserts that GHPs "have become the dominant organizational model for addressing today's complex global health issues. They produce benefits beyond what individual partners could achieve, including attracting attention and funding to diseases, spurring countries to craft smarter policies that plan for the future, encouraging countries to strengthen program monitoring and accountability, and boosting wider stakeholder participation" (McKinsey, 2005).

The enthusiasm evoked by the GPPPs and their novel approach to financing is at least partly the basis of UNITAID, a facility set up in 2005 by Chile, Brazil, France, Norway, and the United Kingdom. Also motivated by sluggish progress on the health Millennium Development Goals, this new entity - itself financed primarily by a levy on airline tickets - has as its mission to scale up access for people in low-income countries to treatment for HIV/AIDS, malaria, and TB. With presently more than fifty member countries and 93 receiving funding, the facility has raised USD 1.5 billion since its beginning. By leveraging price

reductions and thus cutting the long-term cost of drugs, UNITAID finances three out of four children receiving AIDS treatment throughout the world (UNITAID, 2009?).

Recounting the new ideas for raising money for global health assistance, an article in *The Economist* states that in 2007 the non-traditional financing contributed by firms and charities exceeded the 'all sources' total spent in 1990 (Anon., 2010).

#### *Innovative Financing?*

To take the last claim first, the reality is, in fact, far more mixed than the above suggests. As *The Economist* states, funding of GPPP activities has increased significantly, from USD 114m, or 2% of total expenditure on development assistance for health in 1990, to USD 3.86bn, or 18%, in 2007 (Institute of Health Metrics, 2009). However, the origin of GPPP resources is by no means solely private - indeed far from it.

Between its creation in 2001 and 2007, contributions to GFATM reached an impressive USD 12.8bn. Of this, 12.1bn, or 95% had come from governments or the UN system, less than five percent from the private sector. As for GAVI, total revenue since 1999 amounts to USD 4.5bn. Of this, 39% derives directly from public sources, 35% from the International Finance Facility for Immunisation (IFFIm), a financial instrument created by France, Italy, Norway, South Africa, Spain, Sweden, and the UK, and 26% were private funds. Considering 2009 alone, the private share of GAVI's revenue was only 12%, while IFFIm's and direct public contributions made up 50% and 38%, respectively.

Admittedly, the analysis here bears only on GFATM and GAVI figures. It was not possible to determine the distribution of the International AIDS Vaccine Initiative's (IAVI) revenue across its various sources. In terms of required funding the GFATM, GAVI and IAVI make up 82% of the total for eleven GPPPs (Buse, 2007). Seven of the remaining eight partnerships reviewed relied entirely on the Gates Foundation for funding. In other words, and with a reservation on IAVI's income, the overall situation is that the public remains the most important financial source for the large GPPPs and a foundation for the smaller ones. The innovativeness, non-traditionality and additionality of their financing is perhaps less spectacular than at first look.

#### *The Products*

Arguably, the pharmaceutical industry should enjoy a natural advantage in product development

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partnerships based on its product development expertise, entrepreneurial verve, etc. However, the products having come to market on the back of some of the major PDP initiatives, e.g. the Drugs for Neglected Diseases Initiative (DNDi) and the Medicines for Malaria Venture (MMV) were mostly developed from existing compounds and remain limited in number (Matlin et al., 2008).

IAVI has mobilised more than USD 750m since 1996 for the development of a safe, effective and accessible HIV vaccine. As a result, six candidate vaccines have been developed and are being tested. Yet, despite IAVI's impressive scientific record the world still seems far away from the goal – to be able to immunise against HIV - and discovery, development, testing and other research appear to be overwhelmingly carried out in collaboration with public sector entities (International AIDS Vaccine Initiative, 2007).

#### *The Processes*

Many authors have aired concerns and recommendations relative to GPPPs, some comprehensively (Buse et al., 2000, Buse et al., 2007) others dealing with specific aspects (Marchal et al., 2009, Pfeiffer et al., 2010). While the main aim of this paper is to trace the evolution of the PPP appellation and examine the consistency of label and content, other issues, in particular sustainability and accountability, deserve consideration.

Sustainability has different connotations, depending on context and perspective. Buse et al. (2007) estimate the financial shortfall of eleven partnerships, several of which are PDPs, to amount to 60% of requirements. Although not specified in the paper, the figures given would indicate that funding necessary to take a possible new drug through the full-scale requirements prior to market registration – approaching USD 800m - has not been taken into consideration.

Sustainability is also called into question by a certain inconsistency between word and action. On the one hand, by using a vocabulary emphasising notions of long-haul, sustained commitment, and long-term strategy, some, PDPs in particular, are managing expectations as far as their own achievements are concerned. However, at the same time many GPPPs are – inherent to their *raison d'être* – 'monomaniacs' obsessed with quick results. While this issue has been addressed in a number of ways by several of the ventures, the sheer number of mutually incompatible GPPP agendas continues to drain human resources from, cause fragmentation of, and place other burdens on, national health services, in effect to the detriment of

the target clientele and ultimately counterproductive to the efforts of the GPPPs (Hanefeld et al., 2009, Pfeiffer et al., 2010, Windisch et al., 2009).

While the need to respect immaculate accountability principles is evident, again the practical consequences vary with the circumstances. If, as some of the partnerships seem to interpret their obligations in this respect, accountability means being able to “track their gifts right down to the pills received in a remote village” (Anon., 2010), the implication is that logistics are managed in parallel with, rather than in support of, the health system as a whole. An alternative would be to use the platforms, e.g. SWAps, existing or being established in many countries receiving international health assistance. Although the functioning of these structures may vary between countries, they offer a channel for strengthening health systems, including reinforcing accountability, while at the same time simplifying monitoring, evaluation and technical and financial audits – all with the ultimate aim of providing better health services in accordance with government-led and jointly agreed strategies. The two options represent being part of the problem - or part of the solution. The choice ought to be easy.

#### **Conclusions**

As a first observation it seems worth pointing out that variety rather than shared features appears to characterise PPPs and that the usefulness of pursuing a unifying definition is questionable.

Secondly, the main share of overall GPPP financing is provided by governments and charitable foundations. Equally, a large proportion of the R&D accomplished under the auspices of the PDPs, is carried out by public academic institutions rather than by the corporate sector.

Thus, to a degree depending on how one defines 'private', the private P appears to be much less prominent than the public one. In fact, although not demonstrable by the means used here, the PPP term appears to be employed at least partly as a catchy brand name, capturing the *air-du-temps* of much of the past two decades' globalisation, diversification and credence in the efficiency and performance of private business. Irrespectively, the GPPPs' achievements are impressive: in the course of little more than a decade their advocacy - in collaboration with multilaterals and others – has given new momentum to the possibility of improving the health of the poor and getting charities involved in its financing. However, trivialising the difficulties, e.g. single-disease focus, in order to communicate and

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promote issues more effectively has landed some of the partnerships with having to pursue a vertical or parallel approach – at least at country level. By insisting on a particular reading of sustainability and accountability they often impose unnecessary burdens on health systems – contrary to the interest of their stakeholders. Owning up to and addressing these problems are best supported by reliable and consistent evidence.

Thirdly therefore, while most of the GPPPs have undergone evaluations and taken many of the recommendations of these to heart, it would be helpful to carry out such future evaluations within a consistent framework, i.e. a protocol building on work already undertaken (Barr, 2007), including definitions, key comparators and benchmarks against which the relevance, efficiency, effectiveness, impact and sustainability of GPPPs' achievements may be assessed. To lend authority to such a protocol it may be useful to entrust its development to – or with important involvement of – the OECD Development Assistance Committee.

Fourthly, while featuring commonly in the grey literature, in particular in the context of documents relating to SWAps, domestic health PPPs in developing countries appear to be a topic of little published research. Given the global interest in PPPs it is unfortunate that country-level experiences are not generally available. To remedy this is likely to need intervention from the development assistance community, perhaps in the shape of a health PPP information and advisory service set up and hosted by one of the multilateral organisations with a stake and an interest in the subject.

Finally, although not the primary object of this paper, UK PPPs merit consideration not only because they have given global currency to the brand. Whether or not similarly structured or intended, other PPPs ought to be inspired by the same underlying notion, i.e. that by joining forces it is possible to transcend and thus add value to what each 'player' can achieve individually. Indeed, it would be difficult to make a case for international programmes and multilateral organisations spending money - even if donated by charity, large firms, or well-off individuals – to provide health care for poor people in developing countries if the benefits cannot be evaluated in a fashion, which enables a comparison with alternatives.

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