Overseas Development Institute

Briefing Paper 15

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Global health: Making partnerships work

Seven recommendations for building effective global public-private health partnerships.

Key points

- Global public-private health partnerships add significant value in tackling diseases of poverty.
- Evaluations highlight that the value of these partnerships is compromised by a number of common problems.
- Ameliorative actions are workable and need to be mainstreamed so as to realise full partnership potential.

Overseas Development Institute

ODI is the UK's leading independent think tank on international development and humanitarian issues.

Global public-private health partnerships (GHPs) have become increasingly common, jostling for attention in the crowded global health architecture. Initially, they were met by most observers with giddy and unrealistic expectations. Yet a small minority feared that these partnerships represented the thin end of the private sector wedge: encroaching into public health and intergovernmental organisations. They advocated for a moratorium on partnerships until safeguards were put in place to protect the public interest. This minority has been joined by a less sceptical group that is concerned about the transaction costs associated with these ventures as well as other unanticipated consequences. The tide appears now to have turned. Enthusiasm has been replaced with ennui if not fatigue and more critical questions are being asked about whether new initiatives should be launched.

This Briefing Paper, based on research and interviews from some of these partnerships along with findings from external evaluations, suggests what is going wrong, what is going well, and what could and should be going better.[1] It outlines seven contributions made by GHPs to tackling diseases of poverty. Thereafter, it discusses seven habits adopted by many GHPs which result in sub-optimal performance and negative externalities. Many GHPs will need to take seven remedial actions to improve upon these habits to bring about better health in the developing world.

Partnerships: Doing good, better.

GHPs: A unique phenomenon

The decade spanning the turn of the millennium was a crossroads in international health. It witnessed, on one hand, the HIV/AIDS pandemic and resurgence of TB and malaria and, on the other, dramatic increases in financial commitments to fight these diseases, and a fundamentally new approach to tackling them through public-private partnerships. These partnerships marked a watershed, by bringing new actors, resources, business models and a sense of urgency to addressing neglected diseases.

GHPs are relatively institutionalised initiatives, established to address global health problems, in which public and for-profit private sector organisations have a voice in collective decision-making. Partnerships vary but their innovative approach to joint decision-making among multiple partners from the public and private sectors makes them a unique unit of analysis.

Despite frequent claims of the proliferation of so called Global Public-Private Health Partnerships (a figure of 100+ is commonly cited from the database of the now defunct Initiative on Public Private Partnerships for Health), our analysis revealed that only 23 partnerships satisfy our criteria of involving representatives from both the public and private sectors on their decision-making bodies (Table 1).

Table 1: Representation of sectors in GHPs

Global Health Partnership (n=23)	Total Board membership[2]	Low and Middle Income Country Representatives (%)[3]	Private (corporate) sector (%)	NGO (%)
African Comprehensive HIV/AIDS Partnership	5	1 (20)	2 (40)	1 (20)
Alliance for Microbicide Development	7	0 (0)	1 (14)	0 (0)
AERAS, Global TB Vaccine Foundation	9	0 (0)	4 (44)	0 (0)
European Malaria Vaccine Initiative	11	1 (9)	1 (11)	0 (0)
Foundation for Innovative New Diagnostics	4	1 (25)	2 (50)	0 (0)
Global Alliance for the Elimination of Lymphatic Filariasis	6	1 (16)	1 (16)	0 (0)
Global Alliance for Improved Nutrition	16	6 (38)	4 (25)	2 (13)
Global Alliance for TB Drug Development	11	2 (18)	4 (36)	2 (18)
Global Alliance for Vaccines and Immunisations	17	5 (29)	2 (12)	1 (6)
Global Fund for AIDS, TB, and Malaria	23	8 (30)	1 (4)	3 (13)
Global Health Council	13	0 (0)	2 (15)	1 (8)
International AIDS Vaccine Initiative	13	4 (31)	4 (31)	0 (0)
Institute for One World Health	8	0 (0)	4 (50)	0 (0)
International Partnership for Microbicides	12	3 (25)	4 (33)	1 (8)
International Trachoma Initiative	10	0 (0)	4 (40)	0 (0)
Mectizan Donation Programme	18	6 (33)	2 (11)	1 (5)
Microbicides Development Programme	15	6 (40)	1 (7)	0 (0)
Micronutrient Initiative	6	0 (0)	2 (33)	0 (0)
Medicines for Malaria Venture	12	3 (25)	2 (17)	0 (0)
Pediatric Dengue Vaccine Initiative	11	0(0)	1 (9)	0 (0)
Roll Back Malaria	22	7 (32)	2 (9)	1 (5)
Stop TB	32	13 (41)	1 (3)	3 (9)
Vaccine Fund	17	1 (7)	4 (24)	1 (6)
Average		17%	23%	5%

GHPs: delivering improved health

GHPs have made seven impressive contributions to efforts to tackle diseases of poverty (Box 1).

GHPs have been particularly successful in raising the profile of certain diseases on policy agendas, by concentrating on brand-building and public relations. They have been able to mobilise funding commitments, by allocating proportionately more resources to advocacy and communications than do conventional international health organisations. New drugs have been introduced for malaria and leishmaniasis, and more are in the pipeline. These achievements add weight to the argument that GHPs are more likely to lead more quickly to better vaccines than purely private efforts by pharmaceutical companies funded by the public sector through advance market commitments.

A number of product access GHPs have proven remarkably effective in supplying communities with free or reduced cost, quality-assured medicines and vaccines. The Mectizan Donation Program, Stop TB, and the Global Alliance for Vaccines and Immunisation (GAVI) provide three examples. Some GHPs have also had some success in introducing high value goods, particularly antiretrovirals, which has been heralded by many in triumphant terms, but has also sounded alarm bells among economists who are concerned about their cost-effectiveness and sustainability. A number of GHPs are improving national policy-making and institutional reforms in the health sector, and many GHPs are deemed to add value in enhancing efforts to establish norms and standards in treatment protocols, technical management, performance or outcome based planning and financial strategies.

Box 1: Seven contributions made by GHPs to tackle diseases of poverty

- getting specific health issues onto national and international agendas;
- mobilising additional funds for these issues;
- stimulating research and development (R&D);
- improving access to cost-effective health care interventions among populations with limited ability to pay;
- strengthening national health policy processes and content with a focus on outcomes;
- augmenting health service delivery capacity; and
- establishing international norms and standards.

Seven unhealthy habits

Despite their remarkable achievements, the broader picture is one in which these same GHPs commonly practise seven unhealthy habits (Box 2).

Out of 'sync'

GHPs are, by their very nature, issue-specific and quick-results oriented. Their purpose is to focus attention and raise resources for specific diseases, interventions or approaches. To that end, GHPs deploy public relations strategies, partnership champions, third party advocates, and technical experts to achieve their narrow issue-specific goals – often without due consideration of the impacts of their activities on the wider health system. Consequently, it is not surprising to find that GHPs find it difficult to align their assistance with recipient countries' national priorities, or to use national systems for managing their support. Where alignment is poor, there is a that the positive impact of a GHP will be unsustainable.

In whose interests?

GHP's governing bodies often fail to represent all of their stakeholders adequately. As Table 1 illustrates, constituencies from poor countries are poorly represented on GHP boards, with an average of just 17% of the membership across our sample. Non-government organisations (NGOs) are least represented (5%), while the corporate sector, at 23%, has the greatest representation. Figure 1 reveals that representation of government agencies is of the order of 13%.

These results are startling, and raise a number of important questions. Why is the private sector over-represented, when its financial contribution is relatively modest in the majority of these ventures? Why are publicly mandated institutions, such as the World Health Organisation (WHO), under-represented? Why is NGO representation limited, when these organisations have the potential to imbue global health policy, and by extension GHPs, with critical reflection and diverse perspectives? Judged in terms of ensuring relevance, buy-in and effectiveness, the necessity of diverse stakeholder representation on GHP

boards speaks for itself. While there is evidence that some GHPs are becoming more representative, for the remainder, improved constituency management appears a long way off.

Who shall guard the guards?

Many GHPs are failing to keep their governance house in order. Most studies comment on GHPs' inability to specify their partners' roles and responsibilities clearly. This makes it difficult to monitor individual GHP's performance because it is not clear what the partnership is expected to achieve.

Also absent in many cases are procedures governing partner selection, the management of conflicts of interest, and performance and material auditing. GHPs have been subject to considerable criticism because of their potential to prioritise commercial gains over public interest. This is particularly the case when business partners wield undue influence in deciding GHP priorities, or over the content of technical norms and standards which GHPs issue.

Many GHPs are also inadequately transparent. Timely access to relevant information about decision-making processes and substantive information on the issues being deliberated in governing bodies is essential to hold an organisation to account and to enable participants and stakeholders to make meaningful contributions to deliberations. Open and effective communications are particularly critical to create trust in dispersed organisational forms, such as partnership, and trust is critical to partnership functioning. It is of considerable concern, therefore, to find that on such a basic requirement as communication, many evaluations find GHPs wanting.

A 'public' deficit

GHPs are contributing to a diminished sense of global public responsibility. Under-funding of international organisations, such as WHO, represents just one manifestation of this decline. Ironically, while public funding is scarce, many GHPs channel significant public subsidies to research and development in northern-based multinational companies. Another manifestation has been a myopic focus on those diseases most suited to public-private synergy. Diseases such as visceral leishmaniasis, human African trypanosomiasis, and Chagas, which afflict millions of people and result in tens of thousands of deaths annually, have been ignored by GHPs, as have non-communicable diseases. While the utility, or indeed often the necessity of, public-private interaction is not in question, alternative, public, partnership models may be more appropriate when dealing with these 'most neglected' diseases.

Show me the money!

Many GHPs face a crisis of finance – two, in fact. The first is that GHPs lack the necessary resources to carry out planned activities. The data for our study show an average 60% deficit in funding for GHPs. While an arresting figure in itself, the full extent of partners' parsimony is obscured by the fact that a sizeable proportion of GHP financing comes from a single source: the Bill and Melinda Gates Foundation. Seven GHPs rely entirely on the Gates Foundation for funding, and at least nine GHPs list the Gates Foundation as the single largest donor. Should the Gates oasis dry up, the future for many GHPs would be bleak. In addition, the private sector has not generally met the initial, and perhaps naïve, expectations that it would become the principal patron of these initiatives. With a few notable exceptions, the financial support provided by the private sector is very modest in comparison to Foundation donations. The Global Fund provides a case in point: whereas the Gates Foundation has contributed US$150 million, the corporate sector has provided US$2 million.

The second crisis arises because donors have also been miserly in financing the operational costs of running partnerships. Partnership involves intensive consultation and interaction which are expensive activities. Mindful of donor penny-pinching, partnership designers have proposed 'lean', 'business-like' and often 'virtual' secretariats in an attempt to woo financiers (e.g., the TB Alliance). However, keeping down the costs of convening, communication and staff costs is a false economy and severely limits effectiveness.

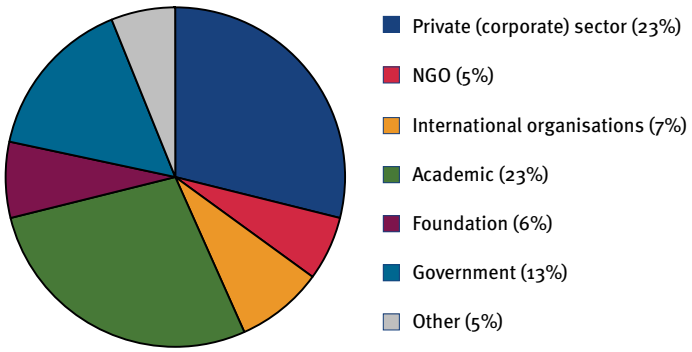
Harmony of the spheres?

GHPs have failed to harmonise their procedures and practices with one another and with other donors leading to duplication and waste. Studies have found many examples of duplication in planning, project-specific monitoring and evaluation, missions and financial management, and parallel systems for health service delivery (e.g. drug procurement and distribution) among GHPs. Although there are posi-

Box 2: Seven unhealthy habits of GHPs

- skew national priorities of recipient countries by imposing those of donor partners;
- deprive specific stakeholders of a voice in decision-making;
- demonstrate inadequate use of critical governance procedures;
- fail to compare the costs and benefits of public vs private approaches;
- fail to be sufficiently resourced to implement activities and pay for alliance costs;
- waste resources through inadequate use of country systems and poor harmonisation; and
- do not adequately manage human resources for partnering approaches.

Figure 1: Composition of Governing Bodies of 23 GHPs



tive signs that GHPs are beginning to harmonise their practices, and a few of the major GHPs are beginning to introduce their own harmonisation strategies, a longer-term approach to strengthening and using national health systems is required.

Pressures of partnership

A final negative habit arises from the organisational commitment and loyalty employers demand of their staff. Secretariat staff in 'hosted partnerships' (e.g. Roll Back Malaria in WHO) are often under intense pressure as they are held to account by their parent (host) organisation, yet find themselves both obliged and actively willing to meet the (sometimes differing) expectations of their partner organisations. As for the staff of 'independent partnerships' (e.g. International Trachoma Initiative), the sheer pressure of rapidly establishing a collaborative arrangement, building an administrative structure and ensuring results carries a heavy personal cost. Moreover, partners' interests do not necessarily always coincide with the interest of the GHP and with other partners, particularly since there is often intense rivalry and turf wars among 'partners' who enter into partnerships – over funding or technical approaches. The difficulties facing staff in negotiating a path through these internecine wars is not often sufficiently well appreciated by partner organisations.

Seven reforms for highly effective partnerships

GHPs, either by commission or omission, have acquired seven unhealthy habits, the consequence of which is that they are more likely to languish in perpetual sub-optimal performance. To encourage the adoption of better habits, there are seven actions that GHPs should take based on lessons arising from partnership experience:

1. GHPs must embrace internationally agreed principles of good aid practices (national ownership, alignment and harmonisation[4]) as well as including as a core partnership function, institutional capacity strengthening for country leadership;
2. GHPs must strive for more balanced representation of stakeholders on their governing bodies;
3. Notwithstanding the reality that public and private interaction of some form is required to meet many global health challenges – the true costs and risks of private sector involvement need to be realistically assessed prior to embarking on new partnership ventures;
4. GHPs should adopt standard operating procedures such as 'SMART' objectives and defined roles, responsibilities and decision rights, and regularly undertake consolidated partnership-wide planning. In addition, partnership metrics are required that can measure partners' strategic interests, public health outcomes from partnership, and overall GHP performance;
5. GHPs should apply standards for the selection of partners; establish systems for managing conflict of interest; ensure that basic elements of transparency are observed; and practice mutual accountability;
6. Partnerships must be adequately resourced to prosper. As a first step partners should set more realistic targets and/or identify specific partners who will plug resource gaps. Secondly, partners need to acknowledge the real costs of alliance management and agree on how to finance them;
7. Partners must manage partnership relationships more carefully. Partners should establish staff rules and incentives; clarify tasks and roles; emphasise consolidated work planning; and acknowledge dual staff loyalties.

Implementing the seven habits

We propose that a simple assessment mechanism be devised to score GHPs on a biennial basis on their performance across a range of good practice indicators. The resulting assessment might help investors (particularly donors and foundations) to make better decisions on supporting GHPs. It might also provide reform-oriented partners ammunition in dealing with recalcitrant partners, secretariats or hosts. The Centre for Global Development's 'Commitment to Development Index,' which assesses rich nations on their aid performance, provides a useful model.[5] The analytical work could be undertaken by the Global Forum for Health Research, which has a mandate in the area of public-private partnerships and the requisite independence, or by the Overseas Development Institute, London, which has demonstrated leadership in improving aid effectiveness. Without an outside push, many partnerships will languish unnecessarily in sub-optimal performance. Sadly, this will result in a lost opportunity to bring improved health to the world's poor.

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Endnotes

1. This Briefing Paper is a summary of original research published by the authors, the results of which are published in Social Science and Medicine 2007; 64(2).
2. Membership includes voting, non-voting, and ex-officio members.
3. LMIC representation is defined as the geographic location of the institution in which the members work. World Bank (2004) is used for country classification: http://www.worldbank.org/data/countryclass/classgroups.htm#Lower_middle_income.
4. As outlined in the 2005 Paris Declaration on Aid Effectiveness
5. Commitment to Development Index 2006: www.cgdev.org/section/initiatives/_active/cdi

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