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Designing Public-Private Partnerships in Health

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Summary:

This primer proposes a new definition for public-private partnerships (PPPs) in health that opens up a flexible range of partnering opportunities while emphasizing the importance of formal agreements and honest brokers in the process. The primer differentiates three types of PPP engagement, using real world examples to illustrate communication, cooperation, and collaboration between actors in different sectors. The author also discusses how combining social and commercial investment will change the nature of PPPs and provides an inventory of common health system gaps that they can address.



Strengthening Health Outcomes
through the Private Sector

1. Introduction

Over the past decade, using public-private partnerships (PPPs) has gained widespread acceptance as a strategy to achieve global health objectives. There is broad recognition that the private health sector can expand its contribution to improving health systems and health outcomes in the developing world. Consensus is less clear around what a PPP really is and what its essential elements are. Conversations about PPPs are often confusing as there are multiple types of partnerships and individuals frequently have differing models in mind when speaking about PPPs.

A clearer taxonomy is needed for effective communication about PPPs that will help practitioners design successful PPPs and establish realistic expectations around what PPPs can achieve. To this end, this paper has two objectives: the first is to clarify the term “PPP” by proposing a new definition, contrasting PPPs with other forms of public-private engagement, and proposing three models of PPPs. The second objective is to clarify when to enter into a PPP for improving health system performance, and when not to, through the use of a simple algorithm. Like all tools in public health, PPPs should only be used when appropriate, and pursuing PPPs when simpler approaches will do wastes time and money.

2. Definition and types of PPPs

Others have written about various forms of PPPs, and attempted to define these relationships. Roy Widdus, former project manager of the Initiative on Public-Private Partnership for Health at the Global Forum for Health Research, has observed that PPP is usually used to describe any form of public-private collaboration, making little or no distinction between the different forms of collaboration.¹ Michael Reich of the Harvard School of Public Health defines PPP simply as a partnership involving one private for-profit organization and one public or nonprofit organization that have agreed to share a common objective to create social value and to share the effort and benefits.² Interestingly, Reich’s definition does not require the direct involvement of the public sector, whose interest may be represented by a nonprofit.

More problematic is the requirement that the for-profit organization share the social objective of the public sector. Whatever desire a commercial partner may express to achieve social objectives, it must be understood from the outset that those expressed intents will be counterbalanced by the need to earn profits. Will the commercial partner merely pay lip service to the social goal in order to earn a profit, or will it accept lower profits to achieve a greater social objective and increase the company’s “social capital” with the government and the local community? When one is engaging a private sector partner, it is impossible to know *a priori* how sincere the

company’s commitment is to the social cause. Moreover, like all institutions, commercial companies are staffed by people who may differ in their levels of commitment to a project, and have varying degrees of authority and stability within the company. The company representative who championed a social cause at the negotiation stage may not be the representative who decides the level of investment at the implementation stage. This makes predicting a firm’s commitment for a multi-year effort highly problematic.

Fortunately, knowing the private firm’s commitment or “true” motivation is not only difficult, it is unnecessary to successful partnering. Partnering with a private company should not require disallowing its need to earn a profit or otherwise support its corporate interest. Its profit motive is just as legitimate as its desire to create social good. Indeed, successful partnerships show that partnering must take account of and accommodate the profit motive. The risks that emerge from the company’s need to promote its corporate interests and earn a profit through a PPP must be managed through careful crafting of agreements and negotiations throughout the life of the partnership.

Another element missing from Reich’s definition is the nature of the agreement. Is it a declaration made at the end of a conference, a nonbinding memorandum of understanding, or a written contract that lays out specific deliverables for each partner and clearly spells out penalties and rewards for each partner? Many PPPs in health rely on informal agreements or nonbinding agreements such as memoranda of understanding. By contrast, PPPs in the infrastructure sector execute detailed, enforceable contracts. This may be because larger investments are at stake in making infrastructure improvements, because governments have more experience in establishing working relationships with the private infrastructure sector than with the private health sector, or because infrastructure partnerships are developed in the context of a tendering and contracting process. When writing about infrastructure PPPs, Francois Michel of the International Monetary Fund cites the following elements as essential:³

1. delivering greater value for money (VFM) than other forms of procurement
2. the contractibility of the quality of service
3. the transfer of a significant share of risks to the private sector
4. the presence of competition or incentive-based regulations

¹ Roy Widdus, “Public-private partnerships for health,” in *The Bulletin of the World Health Organization* (2001).

² Michael R. Reich, ed., *Public-Private Partnerships for Public Health* (2002).

³ <http://blog-pfm.imf.org/pfmblog/2008/02/a-primer-on-pub.html#more>

5. a sound institutional and legal framework
6. a sufficient level of technical expertise in the government
7. the proper disclosure of PPP commitments, along with government guarantees, in government financial statements (and in debt sustainability analysis)

The final element missing from existing definitions of PPPs is scope and purpose. None of the existing definitions describe which health areas are most appropriate for PPPs. Widdus provides excellent examples showing that a major driver of PPPs in health during the past decade has been the development of new treatments and vaccines for communicable diseases, but he stops short of saying that this is the main driver. He argues that partnerships with the private sector are inappropriate in the regulatory area and that engagements with the private sector in service delivery can only be considered privatization, not partnerships.⁴ The Global Fund to Fight AIDS, Tuberculosis and Malaria makes much of its PPPs, but the nature of those partnerships limits the role of the private sector to that of a donor.⁵ The U.S. Agency for International Development (USAID) prefers to call PPPs public-private alliances, but its vision of these alliances (which go well beyond health) recognizes that they “...combine the assets and experience of strategic partners (such as corporations and foundations), leveraging their capital and investments, creativity and access to markets...”⁶

In fact, PPPs may be an appropriate tool to strengthen **any** component of the health system. The approach to PPPs in health will be improved by a common definition that opens up a wide range of partnership opportunities, does not stereotype the rich private sector as a cow to be milked, and stresses the importance of using formal agreements to specify joint responsibilities. The following proposed definition does this:

A PPP in health is any formal collaboration between the public sector at any level (national and local governments, international donor agencies, bilateral government donors) and the nonpublic sector (commercial, nonprofit, and traditional healers, midwives, or herbalists) in order to jointly regulate, finance, or implement the delivery of health services, products, equipment, research, communications, or education.

This definition avoids having to judge the private partners' commitment to the social mission, includes the essential element of a formal agreement, and recognizes the capacity of private partners to strengthen any health system component.

3. What PPPs are not

With this definition in mind, it is important to contrast PPPs with other forms of public-private engagement. PPP and privatization are sometimes used interchangeably. As a result, some people associate PPPs with unpopular programs to privatize state companies by selling them outright.⁷ While a PPP might involve some privatization (e.g., contracting out) of services, a true PPP does not shift all public responsibility to the private sector. For example, when a ministry of health contracts out health service delivery to a private clinic, the ministry is responsible for the clinic's performance of the contracted services and is still accountable to the public.

Partnership is also more than an exchange of information or exchange around policy reform. The Strengthening Health Outcomes through the Private Sector (SHOPS) project has found it useful to distinguish between the three broad types of public-private engagement shown in Figure 1. *Public-Private Interaction* involves the exchange of information between the public and private sector. In the health sector, this may be as basic as the public sector reaching out to ensure the private sector has received and understands government policies and regulations. Conversely, it could involve private health sector providers sharing their data on case detection and treatment with the public sector. *Public-Private Dialogue* goes further—in this type of partnership, the public and private sectors cooperate and negotiate around issues of mutual interest, usually government policies and regulations that impact the private sector. Dialogue does not require a formal agreement or a shared investment, but it does involve both sectors working together to ensure that policy is formulated effectively to have the best possible outcome for the health system.

The third form of engagement, *Public-Private Partnership*, is the most complex. It involves formal agreement between the public and private sector partners, with clearly defined roles and responsibilities for each around their joint implementation of an activity designed to address a weakness in the health system. Typically, the agreement specifies the investment from each partner and the conditions under which each will assume risks and reap benefits.

The three types of public-private engagement are often related—indeed, a single “engagement” may involve interaction as a first phase, dialogue as a second phase,

⁴ Aenean Widdus, op cit.

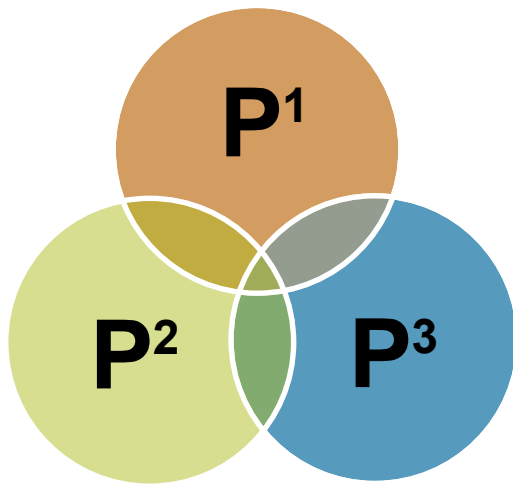
⁵ http://www.theglobalfund.org/en/pressreleases/?pr=pr_101015

⁶ USAID, (Re)Valuing Public Private Alliances (2010, 5).

⁷ Daniele Calabrese, *Strategic Communication for Privatization, Public-Private Partnerships, and Private Participation in Infrastructure Projects* (World Bank, 2008).

leading to a full operational partnership as the summative phase. It is difficult to have cooperation and dialogue if there is no communication or interaction. Likewise, it is unlikely that partners will enter into formal agreements if there has not previously been some level of cooperation. Public-private relationships that involve two or three types of engagement are represented by the overlapped areas of the circles in Figure 1.

Figure 1. Three Types of Public-Private Engagement



P1: Public-Private Interaction:
Emphasis on <i>communication</i> of information to assist each entity.
P2: Public-Private Partnership:
Emphasis on <i>cooperation</i> around an issue of mutual interest.
P3: Public-Private Dialogue:
Emphasis on <i>collaboration</i> formalized in a contract that is jointly designed and implemented.

4. Risks of PPPs

Sania Nishtar, founder of the Pakistani NGO Heartfile, has noted ethical and operational risks involved in the creation of PPPs in health.⁸ They range from the obvious risk of conflicts of interest to the fact that the absence of global norms around PPP creation may lead to negative effects on the health systems that are difficult to foresee. One category of risk that Nishtar does not mention is that of a viable health market being distorted by a PPP, resulting in less sustainability or efficiency in the delivery of health care. This can happen when the public sector chooses to grant a special arrangement to a private sector company that gives the company an unfair advantage in a competitive health market. This

risk exists even if the private partner is not for profit. For example, in some countries, government gives tax privileges and access to free supplies to faith-based clinics even though those clinics charge fees and operate in competitive markets. This may force private clinics in the same market that do not have the same privileges to go out of business. In another example, governments and donors have created NGOs as social monopolies for the distribution of health commodities such as condoms or mosquito nets; this discourages private investments in the commodities and may leave consumers underserved even while the arrangement consumes too large a share of public resources for the service it provides. The fact that these NGOs do not earn a financial profit does not necessarily mean they are better able to serve the health needs of consumers.

Although well-crafted agreements can manage some of these risks, even PPPs that have been effectively negotiated can cause misallocation of resources. Some health PPPs follow infrastructure sector PPP models in order to attract private capital to build large hospitals in exchange for public sector accreditation, staffing, or technical support. Such projects are highly visible and may be politically popular, but they may steer disproportionate amounts of limited public resources to high-end tertiary care for urban, higher-income consumers at the expense of smaller investments in primary care for rural, low-income citizens, thereby increasing inequity in access to care. Many of the health systems in poorer countries create such extreme inequity of access to quality care, with the neediest citizens receiving the least benefit from public investments.

5. Addressing health system gaps

More than well-drafted contracts are needed to manage the risk of health system distortions. First, although this may seem obvious, a PPP in health must be subjected to needs testing, that is, it should address a need that the health system is not addressing. When identifying needs, care should be taken to not confuse a newly emerging, short-term problem to which the health system will adjust with a long-term systemic problem, that is, a health system gap. For example, if an H1N1 influenza outbreak occurs, morbidity and mortality in the population will increase sharply. The immediate response, however, should not be to broker a PPP to deal with the outbreak but rather for the public sector to do public education so that people know how to avoid infection, where to get vaccinated, and where to get treated. Once the health system has had time to respond to the outbreak, the existence of population groups that remain without proper

⁸ Sania Nishtar, "Public-private partnerships in health – a global call to action," in *Health Research Policy and Systems* 2004 2:5.

information or treatment may well signify a **health system gap**. Health system gaps are the failure of the health sectors (public, private for-profit, and private nonprofit) to address persistent, significant public health needs. In this case, a PPP may be the appropriate strategy to bridge the gap. Annex A summarizes how different approaches to PPPs can address these gaps.

To illustrate the difference between a health system gap and a public health need, consider a common gap—a **demand gap** between the health needs of a population and their demand for the products or services that will meet those needs. In the health field, the development of products and services is often based on needs perceived by experts, not by consumers, so supply often precedes demand. Even when consumers perceive a health need, the solutions they demand may not be those recommended by health experts. Take the case of malaria: The public health need is to effectively treat malaria cases and reduce the spread of malaria. A physician prescribes artemisinin combination therapy (ACT) for a patient’s malaria, but the patient opts to use (“demand”) traditional medicine, even when a commercial supplier is supplying ACT at an affordable price and the public sector is providing it for free. Trained, trusted providers can induce demand for the medically correct solution, but in countries where many people self-medicate for malaria, the providers will have only partial success. In short, the health system gap is the difference between appropriate intervention (ACT) and the services demanded by the population (traditional medicine). Until this gap is bridged—until consumers demand ACT—the need for an effective malaria treatment will not be addressed and the incidence of malaria cases will persist. A single-sector approach, such as having the government finance and lead a national communication campaign, could of course potentially bridge the gap by educating consumers about more effective therapies. If, however, the public health system lacks the incentive, resources (financial or communications capacity), or mandate to bridge the demand gap, then developing a PPP to do so might be appropriate.

Widdus puts it more simply: “Partnerships appear to be most justified where traditional ways of working independently have a limited impact on a problem.”⁹ All interventions require time and resources to plan and implement, but PPPs require even more dialogue and negotiation. By definition, PPPs involve working across organizations and people working in two or more sectors—the public or government sector, the nonprofit or faith-based sector, and the commercial or for-profit sector. Each sector has its own “corporate culture,” its own approach to sustaining its activity, and its own advantages and disadvantages for public health. People working in one sector often view people in the other sectors with a mix of incomprehension and distrust. For this reason, designing a PPP usually requires the participation of an

honest broker, a person or organization that is able to speak the language of each sector, understand the needs of each business model, and work with both sides so that each partner gets what it needs to make the partnership work and understand what is expected.

This brokering process can consume appreciable time and money. There should be compelling reasons to justify this expense. Therefore, before programmers decide on a PPP, they should apply the principle of Occam’s razor: choose the simplest intervention that will solve the problem. Only if it is clear that the simpler approach (here, a single-sector intervention) will not serve should programmers adopt the more complex approach of a PPP. Advocates must show that a PPP approach will be better than other simpler or less costly approaches.

6. Ensuring health system performance improvement

To justify the complexity and expense of the PPP process, advocates must show that the private sector has the financial or technical capacity needed to address the health system gap and that the PPP model will be able to improve efficiency, sustainability, or equity in the health system.

Improved efficiency: Efficiency involves rationalizing health inputs to ensure maximum output. Partnerships should strive to reduce duplication and poor distribution of resources to improve efficiency of the overall health system. Separately, the public, nonprofit, and commercial sectors may not have sufficient resources to address a particular problem, but through coordination of efforts and sharing of resources, they should be able to increase health impact. Partnerships that build on complementary roles and assets of each partner can minimize duplication of efforts, overlap of scopes, and wasted resources. The private sector often has significant infrastructure and other resources that PPPs can leverage. Buying excess private sector capacity in terms of expertise or infrastructure is often cheaper than having to pay the full cost of establishing the same capacity in the public or nonprofit sector. For example, when the government sees the need for publicly funded primary care in underserved areas, its first reaction might be to build its own clinics. To do this, the government will also need to provide the systems to staff, supply, and supervise the new clinics. However, if private clinics already exist in the underserved areas, the government could instead contract with those clinics in a way that allows them to expand capacity to provide more primary care. This would improve government efficiency by increasing its output at a lower cost and allow it to husband resources

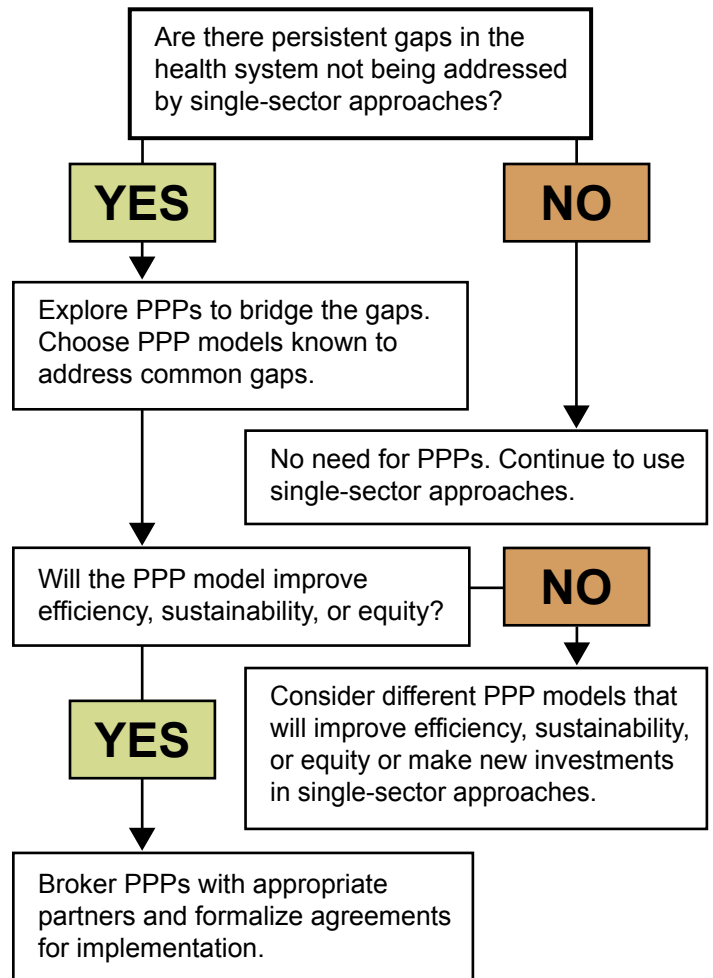
⁹ Widdus, *ibid.*

to establish clinics where private clinics do not exist. It would also help those private clinics, especially if they are commercial providers, to achieve the economies of scale that are so important to their success and sustainability.

Increased sustainability: In the public and nonprofit sectors, sustaining health care delivery depends on maintaining a steady and increasing stream of tax revenues or donations. Unfortunately, many of the poorest countries where populations are growing and health needs are greatest are often unable to steadily finance needed health care. There may be sudden windfalls when the economy is booming or from donor programs, but such windfalls don't last. The boom and bust nature of health financing in the public and nonprofit sectors is itself destabilizing. In such circumstances, leveraging commercial models, which tend to generate more stable revenue streams, can offer greater stability and sustainability to health care provision. A PPP built around commercial models may not be **totally** financially sustainable (i.e., not requiring *any* public or donor subsidies) but they should certainly increase sustainability by shifting the financing from tax or donation resources to market-generated resources.

Increased equity: Virtually all public sector stakeholders recognize that equity in the provision of health care is a critical indicator of success. The public sector is often assumed to have a comparative advantage in reaching the poor, but in many countries, including some of the poorest ones, private commercial providers are the preferred source of health care for the poor. In these circumstances, PPPs designed to improve the quality and affordability of the private provision of care can enhance health system equity. Moreover, there is a variety of demand-side financing mechanisms that can empower the poor to purchase the best health care possible from any sector. Typically such mechanisms involve PPPs because they invest public funds to facilitate consumption of health care in the private sector. The private sector may also serve as an insurer or claims administrator in such schemes. In short, PPPs in health are appropriate when they satisfy a two-stage needs test that is illustrated in the algorithm in Figure 2:

Figure 2. An Algorithm for PPPs in Health



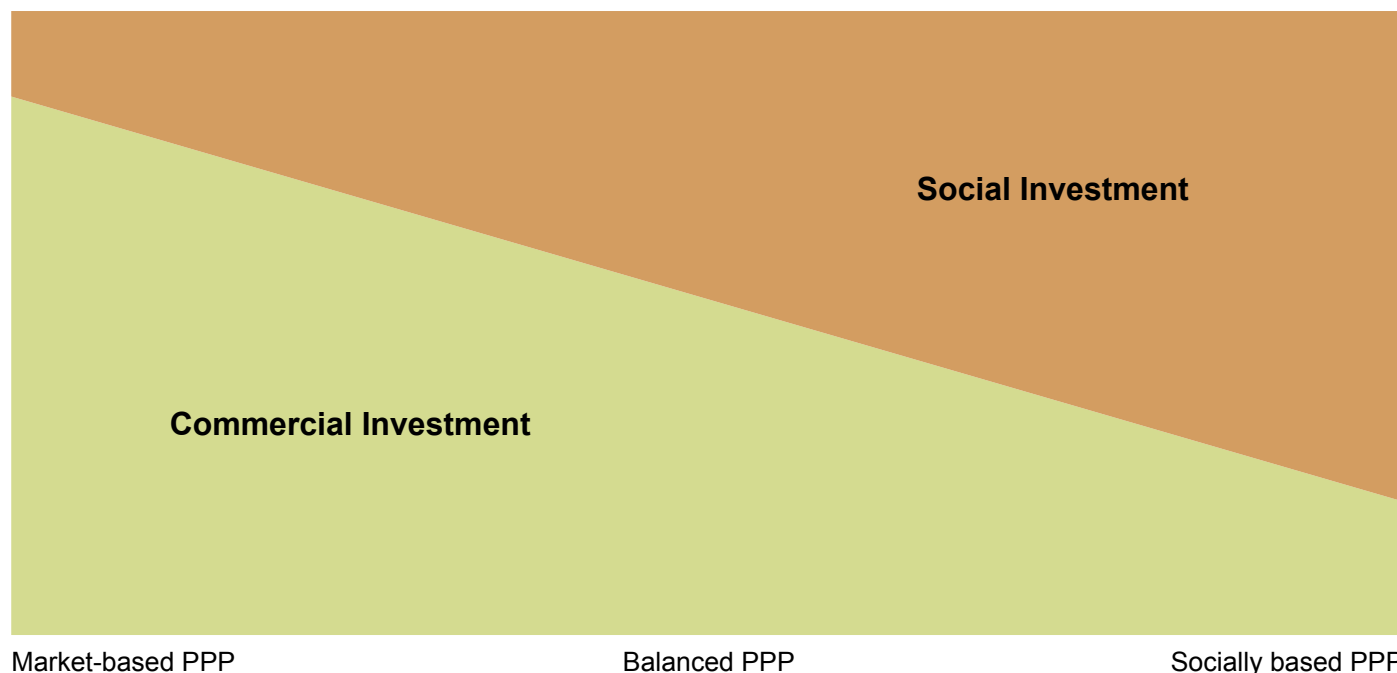
capacity.¹⁰ Almost all documented PPPs fall into these five categories. However, the categories do not address the nature of the contributions from the public and private sector. Nor are the categories mutually exclusive. It is quite possible to have a base of the pyramid partnership that leverages ICT and focuses on building private provider capacity.

7. Three models of PPPs

The final task of categorization involves different PPP models. The purpose here is to orient project programmers to different approaches to creating PPPs and to establish appropriate expectations of the risks and likely results associated with each model. USAID's Office of Development Partners has categorized alliance models into five types: reaching base of the pyramid, strengthening private providers, expanding workplace health, using information and communication technologies (ICT), and sharing expertise and building

¹⁰ USAID, *Building Alliances* (May 2010).

Figure 3. Commercial-Social Mix Defines the Type of PPP



The three models proposed here—market-based, socially based, and balanced—are based on whether the core or foundational activity is commercial (profit-making) or social (improving public health). Every PPP has a double bottom line in terms of having to produce both a commercial return on investment and a social return on investment. The three models differ in terms of their degree of commercial and social investment. The **market-based model** is essentially a commercial, profit-making activity, with the public partner (government, donor, or NGO) making a secondary investment with the objective of enhancing the social impact. The model is sustained through profit generation. The owner or driver of the commercial activity is the private sector partner. The driver of the PPP could come from the private sector or from the government, or be a completely independent broker.

In the market-based model, the social investment is typically time bound and designed to induce the commercial partners to accept a trade-off of lower profit in the short term in exchange for greater growth and profit in the future. Using the previous example of the demand gap for ACT, the social investment could be to support a national educational campaign so consumers understand the advantages of ACT over traditional therapies. In exchange, the commercial partner may be asked to reduce prices to consumers or to pay for some of the costs of conducting the educational campaign. This would result in lower short-term profits, but a much larger market for ACTs in the long term, which would help the manufacturers and distributors of ACT to sustain their activities. It also would increase the long-term health impact.

One real-world example of the market-based model involves Medentech, a commercial company that produces Aquatabs, a point-of-use chlorine water treatment product that it sells primarily to relief organizations like the Red Cross and United Nations High Commission for Refugees. Medentech prices Aquatabs low enough to make the product accessible and still earn a profit. Medentech's margin does not generate enough profit to invest significantly in consumer education and promotion, so Aquatabs has not reached many potential users who suffer from waterborne disease but are not assisted by relief organizations. In Benin, Medentech has entered into a market-based partnership with Population Services International and USAID. USAID's funding is supporting consumer education and promotion and Medentech and its distributor are making the product available for wider consumer use. The short-term investment of public funds in "priming" the market through consumer education will help overcome the **demand gap** to a level that increases the economies of scale for Medentech. Medentech is able to maintain a low price and a much larger number of people can benefit from a health product that will reduce the burden of water-borne disease.

Market-based PPPs also are being used to introduce new drugs and health technologies to treat previously untreatable diseases or to increase access to existing therapies. In this case, public sector support and leadership provide the stimulus to create health interventions that would not otherwise exist, thereby bridging an **innovation gap**. One example of this is the investment that USAID is making with PATH to introduce

a safe subcutaneous, self-disabling injection (Uniject) that can be used to make DMPA hormonal contraceptives more accessible. Until recently, DMPA has only been sold for use in traditional needles, which require more training to use and dispose of. In partnership with Pfizer, the manufacturer of Uniject, USAID and PATH are providing the social investments to make Pfizer's commercially viable product more accessible. This same technology may be used to administer oxytocin to prevent post-partum hemorrhage, which will allow birth attendants or midwives to offer this life-saving medicine on a much larger scale.¹¹

Many market-based partnerships involve sharing of investment risk between the commercial and public sector. While the risk is greatest for drug development because of the high costs and long time required, market-based PPPs created for other purposes, such as product distribution or promotion, also involve the sharing of risk between sectors. There is no guarantee that combined investment in product marketing will guarantee the high levels of use of the product needed to ensure long-term profits and health impact. Nor is there any guarantee that by the time the new therapy is accepted, an even newer and easier to accept therapy will not come along, rendering the earlier investment useless.

Even if use increases and profits generated are sufficient to sustain the activity, there are risks to the social impact. Market-based partnerships typically are short term. If the PPP agreement is nonbinding, it is possible that the commercial partner will not sustain its part of the social bargain when the partnership ends. There is nothing to prevent the commercial partner from changing its marketing strategy from low-margin, high-volume sales to high-margin, low-volume by raising prices, ceasing support for educational campaigns, and so forth.

In a **socially based PPP model**, the core activity is to improve public health. The commercial contribution is designed to expand, enhance, or sustain the health impact. The core activity is sustainable only insofar as it is able to maintain some combination of tax revenues, donations, or corporate contributions. The commercial contribution is often limited to financing, but it could also involve donations of technical expertise, health products, or infrastructure. As with all PPP models, any sector can drive the partnership.

The classic example of the socially based PPP model are corporate social responsibility programs, in which commercial companies help to expand social activities that are typically led by governmental or nonprofit organizations. The pharmaceutical firm Merck participated in a government-led national care and treatment program, the African Comprehensive HIV-AIDS Partnership (ACHAP) in Botswana; a third partner was the Bill and Melinda Gates Foundation. Merck's participation

was motivated by a desire to improve its public image because AIDS activists had criticized it and other manufacturers of antiretroviral drugs for profiting from the AIDS epidemic and not allowing governments to use their intellectual property without proper licensing. Merck's role was to provide program funding, free antiretrovirals, and technical assistance to train health care providers.¹² The partnership was highly successful in that it achieved universal access to quality HIV treatment and significantly reduced mother-to-child transmission of HIV. However, it was dependent on Merck generating sufficient profit in its global business to be able to provide the drugs and expertise for free.

As the Merck example shows, when companies contribute to public health through corporate social responsibility programs, they are more interested in earning a social return—better relations with the host governments and the communities in which the firms operate—than a financial one. In these partnerships, visibility of the activities may be as important to the private sector partner as the actual health impact. In improving their image and enhancing the firm's reputational capital, they are still supporting their larger commercial enterprise, but they are doing so through a social rather than a financial return. As the Merck example also shows, the private sector contribution in these models also depends on the private partner having enough "extra" profit that supporting social welfare is a better use for the profit than investing in operations or returning the profit to shareholders. Obviously corporate profitability is highly variable, so the activities supported through corporate social responsibility models may be short term. ACHAP has been fortunate that Merck has remained profitable enough to maintain support since 2000, but the firm's stated intention is that the donation will be phased out and the government will assume all costs.

A **balanced PPP model** comprises two activities, one commercial and one social, each with its separate owners and revenue streams. The partnership combines the two activities into a new activity; for example, an enhanced social activity that achieves wider scale. However, sustainability of the balanced PPP activity is dependent on both commercial profits and social investments (taxes, donations).

¹¹ <http://www.path.org/projects/uniject-oxytocin.php>

¹² <http://www.merck.com/corporate-responsibility/access/access-hiv-aids/access-hiv-aids-ACHAP-botswana/>

The classic example of the balanced model is the social franchise. On one side of this model, a social franchisor uses public and donor subsidies to provide health provider training, health communications, and product distribution. On the other side are commercial private providers who operate independently and require profits from fees to sustain their practices. The symbiosis benefits both sides: the social franchisors disseminate health messages, products, and training more efficiently and the private providers (the franchisees) receive low-cost training and subsidized products inputs that allow them to expand the range of services, improve the quality of care, and potentially, expand their client flow. One such social franchise is Greenstar in Pakistan. Greenstar, which provides family planning, obstetric, and other reproductive health services, has grown extensively, but still requires significant public sector support to sustain the social contributions that fund its private practices.¹³

Cause-related marketing is another balanced model because it solicits donors to make contributions, but it also leverages profit on consumer items. The RED campaign, which U2 star Bono helped establish to finance the Global Fund to address AIDS in Africa, is one example. The RED brand was developed by the campaign to raise awareness of AIDS in Africa, and it is used by consumer goods companies such as Apple, Converse, and Starbucks to sell their products. A share of the profits on the RED-branded products is contributed to the Global Fund.¹⁴

8. Conclusion

It is the intention of this paper to contribute to the understanding and appropriate application of the PPP approach to produce partnerships that strengthen health systems around the world. Although PPPs in health have grown tremendously over the past 10 years, much remains to be learned about measuring their benefits, as well as documenting and managing their risks. The best possible result of the current PPP trend is that experience will result in more knowledge about how to design effective PPPs and that new, replicable PPPs emerge to improve health systems. However, if risks are not managed well, PPPs can be exploited by firms to increase their profit at the expense of the public good. There is also the risk of overusing PPPs, and making the approach increasingly and unnecessarily complicated and costly in terms of time and funding, when simpler, cheaper approaches would serve.

Better understanding and improved practice can also stimulate more PPP entrepreneurs. Typically, PPPs are initiated by the public or social sector, but with a better understanding and a common vocabulary, the commercial sector can also initiate them. After all, why shouldn't commercial providers approach public policymakers individually or collectively with proposals to make social

investments that allow commercial providers to make a greater contribution to public health? The public sector will have to perform due diligence when selecting private sector partners, but there is no reason that all partnerships must start in the public sector.

As experience in PPPs grows, the process for implementing them can become more routine and more suitable for transparent procurement processes. At present, honest brokers may be needed to negotiate and shepherd the different sectors into well-designed, productive PPPs. However, as more governments understand the principles of PPPs, and more commercial companies gain experience in them, outside brokers will be needed less, thereby reducing the time and expense to design and implement effective partnerships.

¹³ <http://www.greenstar.org.pk/who-we-are.htm>

¹⁴ <http://www.joinred.com/>

Annex A: Health Systems Gaps and Possible Solutions

Health System Gap	Health System Gap	Single-sector Solutions	PPP Solution
<p>Demand gap</p>	<p>A segment of the population has a significant health need and appropriate health products and services exist to address the need, but these solutions are underused because the population does not demand them. The consumers either do not perceive their own health need or they do not perceive that the health solutions are effective or feasible.</p> <p><i>Example:</i> In a country with high HIV prevalence, condom use for prevention of HIV and sexually transmitted disease is very low.</p>	<p>The government uses tax revenues to conduct consumer education campaigns and distribute condoms for free to everyone who asks for them.</p> <p>Nonprofit charities raise donations to procure condoms, distribute them for free, and conduct condom promotion campaigns that increase risk perception and reduce stigma around condom use.</p> <p>Commercial condom companies distribute condoms outside pharmacies, especially in urban areas where commercial sex occurs.</p>	<p>Government leads a consortium of NGOs and commercial condom companies to destigmatize condom use through a multimedia campaign that is also supported by condom manufacturers. Commercial condom brands are promoted in urban areas while targeted free distribution of condoms is done by government and NGOs in rural areas.</p>
<p>Affordability gap</p>	<p>A health service is needed for good health outcomes and demanded by the population. The service can be offered sustainably, but only a small segment of the population can afford to pay for it.</p> <p><i>Example:</i> HIV-positive people want to receive antiretroviral therapy (ART) but they cannot afford to pay for the full cost of the drugs or the care.</p>	<p>The government raises tax revenues to cover the full cost of ART and provides it for free to all citizens who seek it.</p> <p>Nonprofit clinics raise donations from foreign charities and offer free or highly subsidized ART.</p>	<p>In addition to providing ART in the public sector, at subsidized prices, the government offers vouchers to low income HIV-positive patients who can use the voucher to receive reduced-price ART at nonprofit or for-profit clinics. To be in the scheme, the government accredits private clinics and improves the quality of service. Accreditation allows private clinics to obtain reduced-price ARVs through the government procurement mechanism. The increased number of clients allows the nonprofit and for-profit clinics to achieve greater economies of scale, allowing them to reduce their costs and prices overall.</p>
<p>Access gap</p>	<p>A health product is needed for improved health outcomes and is demanded by the population. Both the public sector and the private commercial sector can supply the product, but only in urban areas. The public sector supply chain has too few rural delivery points and the product is too voluminous to displace essential drugs. Commercial suppliers can deliver to rural areas, but the transport costs are too high and the profit margin on the product is too low to warrant the investment.</p> <p><i>Example:</i> Insecticide-treated mosquito nets are unavailable in rural areas.</p>	<p>Nonprofit charities collect donations to fund the purchase of the nets, buy vehicles, and pay for staff and transport costs to conduct free distribution campaigns in rural areas.</p> <p>The Global Fund can provide funding to the government to conduct free distribution campaigns for nets.</p>	<p>The government uses its Global Fund grant to contract with commercial companies that distribute consumer goods in rural areas to deliver nets to community leaders at a lower cost than direct distribution by the government. The donor provides vouchers to low-income rural consumers for nets. Rural retailers are accredited to redeem the vouchers, which are priced to cover increased transport costs. Retailers develop their own sources of supply for nets through the commercial system and nets are available at affordable prices to rural consumers.</p>

<p>Information gap</p>	<p>Health needs of a population segment go unsatisfied because policymakers in the public sector and providers in the private sector lack the information they need to put sufficient priority on the problem and adopt appropriate strategies.</p> <p><i>Example:</i> Use of contraceptives is low and unmet need is high in spite of availability of service providers and contraceptives. Government and family planning nonprofits are unclear about how to promote increased use because no one has financed a demographic health survey in the past 10 years.</p>	<p>The government increases taxes in order to pay for a Demographic and Health Survey that collects information on barriers to use.</p> <p>Nonprofits collect donation to conduct selected qualitative research among nonusers to explore their reasons for not using contraceptives.</p> <p>Commercial suppliers of contraceptives analyze sales data to focus increased detailing efforts to prescribers in areas where sales are lowest.</p>	<p>The government leverages its budget, nonprofit donations, and commercial contributions to conduct a multi-stage nationally representative survey that explores reasons for use in depth. Commercial companies and NGOs have input on design of the study and are able to make use of the results in designing more effective communications and marketing strategies.</p>
<p>Innovation gap</p>	<p>A health need exists for a population because no therapy exists to effectively prevent or cure a disease. No research is being done to develop new therapies because most of the people who are likely to suffer from the disease live in poor countries and have little income.</p> <p><i>Example:</i> No effective vaccine or treatment exists for H1N1 influenza. Pharmaceutical manufacturers are reluctant to invest in the research and development (R&D) due to the uncertainty of success, and high costs.</p>	<p>Governments use taxes to fund R&D and national universities and lab.</p> <p>Commercial companies invest limited funds in development of strains limited to wealthy countries.</p>	<p>Multiple national governments and World Health Organization partner with large pharmaceutical companies, universities, and foundations to conduct R&D on all likely strains of the flu and share investment risk. National governments commit to purchasing specific quantities at a target price. Patent and licensing agreements are also negotiated in advance.</p>
<p>Human resources gap</p>	<p>A health need exists and a service can satisfy that need but the number of trained providers who are skilled to perform the service are limited, especially in the public sector where most lower income consumers seek the service.</p> <p><i>Example:</i> Many women with unmet need for family planning desire long-term methods. Intrauterine devices (IUDs) and implants are readily available in the public and private sector, but government policy requires that only ob-gyns are qualified to insert implants. There is an acute shortage of ob-gyns in the public sector, although in urban areas there are many in private practice.</p>	<p>A nonprofit family planning NGO establishes new clinics, hires ob-gyns trained in the public sector to offer more IUD and implant insertions at subsidized rates.</p> <p>The government raises tax revenue to hire more ob-gyns to serve in public sector clinics.</p> <p>Private sector ob-gyns promote their IUD and implant services.</p>	<p>The government negotiates a policy reform with the ob-gyn professional councils to permit nurses and midwives to insert implants and IUDs. The family planning NGO raises donor funds to promote the policy change and to train nurses and midwives from the public, nonprofit, and commercial sector in the procedures. The commercial supplier of IUDs also sponsors some of the training sessions. In rural areas, government contracts with private ob-gyns to provide IUD and implant insertions on a monthly basis to all women who have requested them.</p>

Annex B: Comparison of Three Models of PPPs

	Core Activity	Duration of Social Investment	Need of Private Partner	Sustainability	Partnering Risks
Market-based PPP	For-profit commercial business	Short term	Financial profit	Dependent on profitability of the commercial activity.	<ul style="list-style-type: none"> Commercial activity may fail. Commercial partner may retreat from social objectives after the duration of the partnership. Public investment may be too small or too short term.
Socially based PPP	Nonprofit public health activity	Long term	Improved public relations, better company image with local government and local community	Dependent on continued support from company profits, government tax contributions, and/or private donations.	<ul style="list-style-type: none"> Instability of corporate and private contributions. Private partner may not achieve improved relations as expected. Public or donor funding may be insufficient, irregular, or too short term.
Balanced PPP	Both for-profit commercial activity and a nonprofit health activity	Long term	Financial profit and improved public relations	Dependent on both profitability of the private activities and on donations or government tax contributions.	<ul style="list-style-type: none"> Benefits of partnership may be difficult to demonstrate. May revert to separate, less efficient implementation.

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To access the capabilities of SHOPS, USAID missions and bureaus can buy into the leader agreement or issue their own associate awards.

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