INTERNATIONAL ETHICS

# Public-private partnerships and global health equity: prospects and challenges

**AUGUSTINE D ASANTE[1], ANTHONY B ZWI[2]**

**[1]National Centre in HIV Social Research, [2]School of Public Health and Community Medicine, The University of New South Wales, Sydney NSW 2052, AUSTRALIA**

***Abstract***

*Health equity remains a major challenge to policymakers despite the resurgence of interest to promote it. In developing countries, especially, the sheer inadequacy of financial and human resources for health and the progressive undermining of state capacity in many under-resourced settings have made it extremely difficult to promote and achieve significant improvements in equity in health and access to healthcare. In the last decade, public-private partnerships have been explored as a mechanism to mobilise additional resources and support for health activities, notably in resource-poor countries. While public-private partnerships are conceptually appealing, many concerns have been raised regarding their impact on global health equity. This paper examines the viability of public-private partnerships for improving global health equity and highlights some key prospects and challenges. The focus is on global health partnerships and excludes domestic public-private mechanisms such as the state contracting out publicly-financed health delivery or management responsibilities to private partners. The paper is intended to stimulate further debate on the implications of public-private partnerships for global health equity.*

## Introduction

Healthcare delivery is primarily the responsibility of national governments. However, in many developing countries the sheer inadequacy of financial and human resources has hampered efforts by governments to deliver healthcare to all who need it. Inefficiencies in the public sector have also undermined the effective delivery of healthcare even in those countries where resources are available. With inequities in access to healthcare and essential medicines widening both within and between nations, the need for additional resources and efficient delivery strategies has never been more pressing.

Access to effective HIV/AIDS treatment, for example, remains largely inequitable worldwide. In India, a country which supplies about half of the developing world's HIV-positive population with life-saving generic antiretroviral drugs, access to treatment is between 6 per cent and 15 per cent – well below the 28 per cent average for low- and middle- income countries (1). In many sub-Saharan African countries including Ghana, Tanzania and Democratic Republic of the Congo, access to antiretroviral drugs, despite recent improvements, remains under 20 per cent. This contrasts sharply with the situation in the developed world where over 50 per cent of patients have access to HIV medication. In Australia about 70 per cent of the 15,310 people living with HIV in 2005 had access to treatment (1, 2).

Public-private partnerships have been explored as a mechanism through which to mobilise additional resources and support for health activities, particularly in under-resourced developing countries. Over 80 such partnerships exist, many focusing on combating neglected diseases or engaged in developing new drugs or vaccines (3). The UN and its agencies have been at the forefront of engaging with the private sector in an attempt to foster collaboration that would deliver more resources for health in poorer countries (4). The World Health Organization (WHO) has identified partnerships with civil society organisations, philanthropic foundations and the for-profit private sector as key to the future of global health (5). This burgeoning collaboration with the private sector is in accordance with the United Nations' Global Compact which seeks to increase and distribute the benefits of global economic development through voluntary corporate policies and actions in the areas of human rights, labour, the environment, and good governance (6, 7).

Enthusiasts of public-private partnership such as the World Bank believe these partnerships could help address specific cost and investment challenges faced by governments and improve efficiency and quality of health services (8). Others like the WHO and several pharmaceutical companies think public-private partnerships can contribute to improving equity in access to essential drugs while enhancing research into some of the world's forgotten diseases such as trypanosomiasis, buruli ulcer, tuberculosis and malaria, all of which predominantly affect the poor (9, 10).

While public-private partnerships are conceptually appealing, many concerns exist. The structures and governance arrangements under which these partnerships operate have been critiqued, as has been their potential impact on healthcare delivery in the international context, particularly their implications for global health governance. Not so much debate, however, exists on how public-private partnerships improve or undermine global health equity. This commentary considers the viability of public-private partnerships for improving global health equity and highlights some of the key prospects and challenges. The focus is on global health partnerships and excludes domestic partnerships such as the contracting out of publicly-financed health delivery and management responsibilities to a private partner or partners.

The paper is intended to stimulate debate on the implications, for global health equity, of public-private partnerships and motivate evaluative research into the equity impacts of these collaborations.

## Overview of types of public-private partnership

Public-private partnerships come in diverse forms and can mean different things to different people. While the terms "public" (state-financed and controlled) and "private" (non-state actors operating solely for profit or on a not-for-profit basis) are less controversial, that of "partnership" is loaded with ambiguities and has no single acceptable definition. It has been used to describe a variety of collaborations between different actors. Literally, it implies the commitment to a common goal through the joint provision of resources and expertise and the sharing of risks (11). In the health sector, public-private partnership commonly refers to any partnership in global health involving government and/or inter-governmental institutions and industry (12). To some people, collaborations between government institutions, particularly ministries of health and non-governmental organisations, are good examples of public-private partnership. For purposes of the analysis in this paper, the WHO's definition which sees public-private partnership as the "means to bring together a set of actors for the common goal of improving the health of a population through mutually agreed roles and principles" appears more appropriate (13).

Lob-Levyt (14) identified three main foci for public-private partnerships in health – products, outcome and activities. Product-oriented partnerships cover efforts to increase investments in research and development into new drugs, vaccines and diagnostic tests in the face of dwindling funding for research focusing on diseases that disproportionately affect the world's poor. In these partnerships, links between public sector institutions, the pharmaceutical industry and philanthropic foundations are considered crucial. Pharmaceutical companies usually possess the technology as well as manufacturing and distribution expertise. These can be paired with funding from public sector partners such as governments or philanthropic foundations like the Gates Foundation to invest in vaccine and drug research and development. In order to provide incentives for the development of a particular drug, tax credits may be offered to the companies involved, or agreements may be established for advance purchases to guarantee markets for the product if it is developed. The Global Alliance for TB Drug Development involving Glaxo Smith Kline and other partners is an example of product-oriented public-private partnership.

Outcome-oriented partnerships usually involve government institutions, industry and/or private philanthropists teaming up to fight certain poverty-related diseases such as polio. A typical example is the Global 2000 initiative of Jimmy Carter, former US president, which aims at eradicating guinea worm infection (one of the world's most forgotten diseases) in endemic sub-Saharan Africa and other developing countries. The Global Alliance for Vaccines and Immunisation and the Global Programme to Eliminate Lymphatic Filariasis are other examples of outcome-oriented partnership.

Finally, activity-focused partnerships may encompass the coming together of a number of organisations to work on developing a particular drug for a particular disease. The partnership between Hoffmann La Roche and Basilea Pharmaceutica – both of Switzerland – and Fulcrum Pharma of the UK to identify next-generation oxonides that will provide a single-dose oral cure for patients with uncomplicated plasmodium falciparum malaria under the Medicines for Malaria Venture is a good example of an activity-focused partnership. An activity-focused partnership can also be one that employs private sector mechanisms in the delivery of public goods, for example, the social marketing of commodities such as condoms and bed nets.

While the above classification may serve analytical purposes, there are a plethora of collaborations in the health sector that could be described as public-private partnerships and it is not always clear how best to describe or position them.

## Public-private partnerships and global health equity

Underlying the bulk of global partnerships for health is the desire to bridge the inequity gap in healthcare access between rich and poor countries, especially access to essential drugs, and to develop new vaccines for diseases of prime importance to poorer nations. In particular, partnerships involving the UN agencies consider equity a primary goal as the organisation appears to have rediscovered its core equity values in recent years. But to what extent do these partnerships seek to and actually deliver on equity? Evidence of how public-private partnerships in the health sector have affected global health equity is scarce. In addition, scepticism about the profit motives of private corporations involved in these partnerships, especially pharmaceutical companies, often leads people to overlook any of their potential equity benefits. Indeed, many have criticised what they perceive to be an "open invitation" to private corporations to play a greater role in healthcare delivery, citing the risk of exacerbating current inequities in health as a major concern.

The rest of this paper considers the prospects and challenges of public-private partnerships for improving global health equity. As noted earlier, within the international health arena there are a variety of joint initiatives that merit the description of public-private partnerships. We focus specifically on global health partnerships involving private for-profit companies, particularly those in the pharmaceutical industry.

## Prospects for improving global health equity

Conceptually, health equity, irrespective of how one interprets it, requires extending access to healthcare to a broader range of citizens whether or not they have the ability to pay for the services. This seems inherently contradictory to the objectives of private companies which are established largely to make profit. So is there any evidence that global health equity has been improved through public-private partnerships?

Recent update on the HIV/AIDS pandemic by UNAIDS/WHO clearly shows an increase in access to treatment and care in low- and middle-income countries. In sub-Saharan Africa, for example, the number of people receiving HIV/AIDS treatment increased more than eight-fold from about 100,000 to 810,000 between 2003 and 2005 and more than doubled in 2005 (15). This massive improvement would not have been possible without key public-private partnerships in the HIV/AIDS sector. Partnerships such as the Accelerating Access Initiative, formed in 2000 between some UN organisations and a number of pharmaceutical companies, the Drug Access Initiative and the 3 by 5 campaign have, through price bargaining and discounting, significantly reduced prices for antiretroviral drugs in poorer developing countries, making them more affordable. Much of the HIV medications are sold today in Africa and elsewhere in the developing world at discounted prices far lower than their original prices. For example, since 2001, Abbott has been selling HIV medications in 69 least developed countries including all of Africa at $500 per patient per year; the same drug costs approximately US$7,500 per patient per year in the US (16).

In addition to the discounted prices, there have been several global donation initiatives which have enhanced equity by making HIV drugs more accessible in developing countries. The Viramune Donation Programme, for example, has since 2000 donated nevirapine for the prevention of mother-to-child transmission while the Diflucan Partnership Programme has donated fluconazole for treatment of opportunistic infections from 2001. Under the Africa Comprehensive HIV/AIDS Partnerships with the Bill & Melinda Gates Foundation, the government of Botswana receives donation of Stocrin and Crixivan from Merck to boost its HIV/AIDS treatment campaign (17).

Apart from HIV/AIDS, public-private partnerships with pharmaceutical companies have contributed significantly to combating other "neglected" diseases such as leprosy, onchocerciasis, lymphatic filariasis, malaria and tuberculosis. These diseases have debilitating effects on their victims in poorer countries where resources to fight them are significantly limited. Through public-private partnerships such as the Global Alliance for Vaccines and Immunisation, the Mectizan Donation Programme, the Global Alliance to Eliminate Leprosy and the STOP TB initiative, there have been vaccines and considerable financial and material resources to combat some of these diseases as well as to raise their sinking profile on the global health agenda. The above examples clearly demonstrate the important role that public-private partnerships can play in improving global health equity. There are, however, several challenges that must be overcome for these partnerships to contribute effectively to enhancing global health equity.

## Challenges for improving global health equity

Concerns about the viability of public-private partnerships to improve global health equity revolve around several issues including the profit motives of the private sector. Private companies seek to maintain profitability in order to survive and thrive as business entities. However, with the push to give globalisation a human face, these companies want to be seen as socially responsible in their quest for profit. While in public most of them are keen to demonstrate their "good corporate citizenship" credentials, particularly how they are helping poorer nations to access drugs at affordable prices, in private they may take actions that are largely motivated by profit and contradict claims of good corporate citizenship. Regarding access to HIV/AIDS medication, for example, although prices of antiretrovirals have dropped significantly in poorer countries, it took strong political pressure and campaign by AIDS activists for pharmaceutical companies to reduce prices.

There is evidence suggesting that several multinational drug companies still engage in policies that restrict universal access to antiretroviral drugs. For example, the World Trade Organisation recognises the importance of access to essential medicines in times of public health crisis and gives governments some freedom in the Trade-related Aspects of Intellectual Property (TRIPS) to bypass patents on drugs in emergency situations. However, several pharmaceutical companies involved in public-private partnerships have also promoted policies limiting the capacity of governments in developing countries to use TRIPS flexibility to improve drug access (17). The recent row between the government of Thailand and Merck, Abbott and Sanofi-Aventis over the planned manufacture of generic copies of the antiretrovirals Efavirenz and Kaletra and the heart drug Plavix under the TRIPS flexibility provision illustrate the desire of pharmaceutical companies to limit access in order to maximise profit. Without underestimating the importance of patent rights, such actions do not promote global health.

Another challenge regarding global health equity is the limited transparency and accountability surrounding public-private partnerships. Often, partnership arrangements with the private sector are not open to public scrutiny. The process of selecting private partners, the setting of targets to be achieved and the formulation of management guidelines are anything but transparent. Partnerships involving UN agencies, including the WHO, and private corporations usually fail to involve poorer developing nations who are often the main beneficiaries of such collaborations. The apparent lack of openness makes it difficult to assess what equity targets are set and who should be held accountable for achieving those targets, if any. It is also difficult to hold private companies accountable for failed public-private partnerships given their complex structures and governance, and the different processes of accountability within the public and private sectors. While public sector organisations are theoretically accountable to the population and could be held responsible for issues such as equity, private companies are answerable to shareholders who are typically more concerned about returns on investments than improving equity.

Competence to negotiate a mutually beneficial partnership agreement differs between the public and private sectors. Many public-private partnerships in the health sector today exist between governments of poorer developing nations

and pharmaceutical companies. Most of these governments depend largely on donor funding for their healthcare provision and this may come with strings attached. Governments engaging in direct partnerships with private companies may negotiate from a weak position depending on the source of their donor support. By contrast, pharmaceutical companies have tremendous technical and financial clout and are often backed by powerful governments. The US government's aggressive defence of intellectual property rights of American pharmaceutical companies is well known (18). The massive influence of private companies could be used to dictate partnership terms and conditions to suit commercial interests and this could have severe repercussions for health equity.

Furthermore, public-private partnerships in the health sector have focused overwhelmingly on improving drug access. While this is crucial in many health systems, particularly in poorer nations, there is more to health equity than simply improving access to medicines. Equity in health, according to Sen (19), should be assessed in terms of health capabilities and achievements rather than healthcare activities. Improving drug access by cutting down prices is necessary but not sufficient to improve equity. Reasonable consensus exists among health economists that individuals have different capacities to benefit from healthcare (20) and that access to services is not synonymous with utilisation of healthcare. In sub-Saharan Africa there is ample evidence suggesting that despite improvements in access to antiretroviral drugs the bulk of people with HIV/AIDS are still without access (15). In short, equity requires adequate social arrangements that provide individuals the opportunity to achieve good health (21). It cannot therefore be effectively promoted through partnerships that focus narrowly on improving drug access; rather, it must to be pursued as part of a broader reform to strengthen health systems.

Finally, there are concerns that public-private partnerships in the health sector could threaten global health governance and derail the promotion of equity. The health sector needs strong leadership if equity objectives are to be seriously pursued. At the global level, the WHO is generally regarded as the natural leader. However, the organisation's increasing participation in partnerships with private corporations has offered the private sector a platform to actively engage in global health decision-making. There are fears that as profit-seeking corporations gain louder voice in decision-making, the WHO's leadership might be compromised and this could adversely affect the promotion of equity.

Another source of worry with regards to leadership and equity is the growing influence of the World Bank on the international health stage. Relying on its massive funding power, the World Bank has, over the past 15 years, entrenched itself as the leader in global health development. It is currently the world's largest external funder of health, committing more than $1 billion annually in new lending to improve health, nutrition and population in developing countries. In the fight against HIV/AIDS, its commitment (among the largest in the world) stands in excess of $1.3 billion, with about half of it going to sub-Saharan Africa (22). While funding from the World Bank is crucial to the efforts to improve health, there are concerns that equity considerations may suffer if neoliberals in the Bank dominate. The bank's traditional support for market mechanisms including privatisation of the health sector particularly makes many equity advocates nervous.

There are also concerns about the impact of public-private partnerships on health sector governance at country levels. In many countries, the evidence suggests that national ownership of health programmes has suffered with the increase in public-private partnerships. In Zambia and Uganda, for example, Caines and Lush (17) found little indication of national ownership of HIV/AIDS public-private partnerships programmes. Non-governmental organisations, in most cases, own and control these programmes. The limited national ownership of such programmes can potentially harm domestic policies and strategies designed to promote health equity. There is the need, however, for further research into how specific global public-private partnerships have affected health sector governance and how this in turn has enhanced or undermined equity as concrete evidence at country levels in this area remains scarce.

## Conclusion

The growing inequities in health and access to healthcare worldwide require serious global attention and strong leadership from the WHO and national governments. Partnership with the private sector brings to the public health sector private financing and private sector know-how. In several instances, it has contributed to improving access to essential medicines in poorer countries and helped to mobilise additional resources and support for healthcare in the face of declining investments and rising demand for services. However, in terms of equity, public-private partnership is like a double-edged sword – it can promote as well as undermine fairness in global health. Private companies are established to generate profit and will not invest or participate in partnerships where the opportunity to make profit does not exist. The public sector stands the risk of subsidising the commercial sector with public funds if it does not go into these partnerships with well defined goals and achievable targets. It is incumbent on all governments and inter-governmental agencies engaging in partnership with the private sector to set out clear goals for improving global health equity and ensure that these goals are achieved. This should go beyond narrowly promoting equity in access to essential medicines and target improving overall equity in health by paying special attention to the determinants of ill health, the establishment of effective health systems, and improvement of access and quality of care for those worst-off.

***Competing interests:*** *The authors declare no competing interests.*

**References**

1. WHO/UNAIDS/UNICEF. *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. Progress Report.* WHO/UNAIDS/

UNICEF: Geneva; 2007 Apr.
2. National Centre in HIV Epidemiology and Clinical Research. *Annual surveillance report: HIV/AIDS, viral hepatitis and sexually transmitted infections in Australia*. NCHECR: University of New South Wales, Sydney; 2006.
3. Wemos. *Good intentions with side effects: information on global public private initiatives in health*. Wemos: Amsterdam; 2004. [Monograph on the Internet]. [Cited 2007 Jun 7]. Available from: http://www.wemos.nl
4. Buse K, Waxman A. Public-private partnerships: a strategy for WHO. *Bull World Health Organ* 2001; 79: 748-54.
5. Brundtland GH. *One world: global health*. Oral presentation at the annual meeting of the American Public Health Association Atlanta, GA, USA: 2001 Oct 22.
6. United Nations Industrial Development Organisation. *Survey of small and medium enterprises in the global compact*. UNIDO; Vienna: 2004.
7. Williams M. The Global Alliance for Vaccines and Immunisation: is it a new model for effective public-private cooperation in international public health? *Am J Public Health* 2004; 94: 1922-5
8. Nikolic IA, Maikisch H. *Public-private partnerships and collaboration in the health sector: an overview with case studies from recent European experience*. Discussion Paper. World Bank Health, Nutrition and Population (HNP): Washington, DC; 2006.
9. World Health Organization / Joint UN Programme on AIDS. *Accelerating access initiative: widening access to care and support for people living with HIV/AIDS*. Progress Report. Geneva: WHO/UNAIDS; 2002 Jun.
10. GlaxoSmithKline. *A Human Race*. Corporate Responsibility Report of 2006. [Cited 2007 Jun 15]. Available from: www.gsk.com/responsibility/cr-review-2006/downloads/CR-Report-2006.pdf
11. Ridley RG. Putting the partnership into public-private partnerships. Editorials. *Bull World Health Organ* 2001; 79: 694.
12. Bale HE. Reversing failure. In: Ridley RG, Lob-Levyt J, Sachs J, Johns D, Evans T, Bale HE, Quick JD, et al. A role for public-private partnerships in controlling neglected diseases? Round Table Discussion. *Bull World Health Organ* 2001; 79: 771-7.
13. World Health Organization. *Guidelines on collaborations and partnership with commercial enterprise*. WHO: Geneva; 1999.
14. Lob-Levyt J. A donor perspective. In: Ridley RG, Lob-Levyt J, Sachs J, Johns D, Evans T, Bale HE, Quick JD, et al. A role for public-private partnerships in controlling neglected diseases? Round Table Discussion. *Bull World Health Organ* 2001; 79: 771-7.
15. Joint UN Programme on AIDS. *Report on the global AIDS epidemic*. Geneva: UNAIDS; 2006.
16. Abbott. *Generations: Global Citizenship Report 2006*. 2007 Apr. [Cited 2007 Oct 3]. Available from: http://www.abbott.com/static/content/document/2006_gcr.pdf
17. Caines K, Lush L. *Impact of public-private partnerships addressing access to pharmaceuticals in selected low and middle income countries: a synthesis report from studies in Botswana, Sri Lanka, Uganda and Zambia*. Geneva: Initiative on Public-Private Partnerships for Health; 2004.
18. Bond P. *Against global apartheid: South Africa meets the World Bank, IMF and international finance*. Cape Town: University of Cape Town Press; 2001.
19. Sen A. *Inequality re-examined*. Oxford: Oxford University Press; 1995.
20. Culyer AJ. Equity - some theory and its policy implications. *J Med Ethics* 2001, 27: 275-83.
21. Sen A. Why health equity? *Health Economics* 2002; 11: 659-66.
22. Ruger JP. The changing role of the World Bank in global health. *Am J Public Health* 2005; 95: 60 -70.