Public-Private Partnerships for Health and Guaranteeing Drug Delivery through Health Systems: Issues Needing Further Analysis

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Promoting effective collaboration on neglected health problems in developing countries

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A. Overview and Purpose of the Meeting

Gill Walt and Roy Widdus

Public-private partnerships for global health (PPPs) are still social or organizational experiments. We are all learning from each other about PPPs, and the spirit of exchange at the meeting centered around that. Attendees came from a wide variety perspectives: public, nonprofit, commercial. All have been involved in either researching, designing, actual managing, or interacting with PPPs. The focus was on PPPs focused on drug delivery through health systems at the country level. We believe it important to listen to the needs and concerns of all groups in order to identify common areas needing further analysis. The meeting was designed to allow for honest exchanges and discussions respectful of these varying viewpoints.

Overview of PPPs, research on PPPs, and purpose of the meeting

‘Partnership’ is one of the most overused words in global health these days. We must find a common understanding and better define the various kinds of strategic collaborations that are developing to address intractable global health problems. Analysis is needed to determine where partnerships are most appropriate and useful, encouraging the exchange of information and providing value-added analyses and services.

We can analyze existing partnerships more easily and effectively when we first categorize them. For example, we can look at the purpose or health goal of the alliance. Is the purpose to discover or develop a new drug, vaccine, or other health product? Or is the goal to bring an already available health product to the populations that need it but cannot afford it? Or does it seek to coordinate a variety of these activities for a particular disease or condition, to strengthen health systems or delivery infrastructures? Additional categories arise when we ask whether partnerships address a particular neglected disease or condition, or if they are broader in scope.

What kind of product or service is involved? Who are the major participants and funders in the alliance? What is the level of resource commitment needed to fulfill the objectives of the partnership?

We need to understand the various organizational options available to strategic alliances. They can range from informal to formal; a few partners to hundreds; decentralized community-level operations to global central secretariats; and from embedded to independent legal structures.

For example, some health partnerships are embedded within the structure of multilateral organizations such as WHO or UNICEF, while others are embedded in non-governmental organizations, such as PATH or Sabin Vaccine Institute or within a corporation’s philanthropic foundation. Other partnerships are created as independent legal entities (usually as nonprofit organizations, in the U.S., often as 501(c)(3) organizations, from the tax-exempt section of the tax code.). Founding partners usually decide whether to house a partnership within a larger organization or to create a self-standing entity based on their perception of existing organizational structures as either supportive of or limiting operations. Other administrative, fund-raising, political or financial issues may also influence the decision of how and where to structure a partnership.

The purpose of the meeting was to examine in a non-judgmental, comprehensive manner the issues surrounding public-private partnerships involved in drug delivery at country level. There were two main themes: 1) measuring effectiveness and 2) integration into national delivery and health systems.
1. Measuring effectiveness

What returns are generated by the cash or in-kind donations contributed by the funders? How do we value in-kind donations? If a company makes an in-kind drug donation, how can it ensure that these drugs reach the intended beneficiaries? With so little infrastructure available to address delivery issues, whose responsibility is it and who is willing to cover these investments? What information is necessary? Who could gather it and how would it be used?

What are the “value-addeds” and how can they be maximized? What are the unintended side effects and how can they be minimized? Which health indicators can be measured? Do PPPs have measurable objectives and do all the partners agreed on them? Do we want to measure the disease program’s effectiveness at eliminating/controlling the disease, the aspects of the donation program that extend beyond simply disease indicators, or the broader value of the public-private partnership?

2. Integrating PPPs into existing national priorities and drug delivery systems

Many criticisms of PPPs are the same as those leveled against the old, vertical disease-control programs. How do we balance the need for specific efforts to control a particular disease with the need to reduce the duplication of efforts for overworked, under-funded, national and district program managers who must practice systems-wide approaches (SWAps)?
B. Presentations on Selected Public-Private Partnerships

How they measure effectiveness

Joseph Cook
International Trachoma Initiative
(Powerpoint presentation available upon request)

ITI addresses the leading cause of preventable blindness through the SAFE method (Surgery, Antibiotics, Face Washing, Environmental). ITI is disease-specific but, because it makes improvements on the environmental side (improving access to clean water and better sanitation, and to health education), it has cross-sectoral influence and is valuable in the battles against other diseases, too. Although ITI receives donated antibiotics (Zithromax®) from Pfizer, these are not always necessary when face-washing habits and environmental factors are improved (e.g. Tunisia eliminated trachoma without antibiotics). ITI works only with WHO priority countries.

For each element of S.A.F.E., ITI has identified measures of effectiveness. For example:

1. Goals, e.g. <5% TF in <5 years, 80% clean faces, etc.
2. Process, e.g. # trained, # health education sessions, % increase in government programs, etc.
3. Output, e.g. # treated, change in KAP, # latrines, etc.
4. Impact, e.g. % decrease in disease, % clean faces, etc.

ITI is examining how it can use baseline data to make meaningful comparisons to results data. Can these indicators be tracked adequately and regularly over life of the initiative? How can this be implemented? Could it be replicated by other partnerships?

Stefanie Meredith
Mectizan Donation Program
(Presentation available upon request)

The oldest and most well-known donation program still in existence started in 1987, when Merck took the unprecedented step of donating as much Mectizan® as necessary, for as long as necessary, to treat river blindness and bring this public health problem under control. Merck discovered and developed Mectizan; WHO opined that it was safe for mass distribution. Merck also pays for all shipping and handling to countries in need (but requires that countries provide duty exemption). The program works closely in each country with MOH, which has final authority. They also coordinate donations of Mectizan to be used in combination with Albendazole, to treat lymphatic filariasis in areas where river blindness is co-endemic.

Mectizan is generally considered an appropriate donation because it was the best available drug in existence, was not commercially available, was easily administered, and because there was a partial infrastructure already functioning from the long-standing Onchocerciasis Control Program (OPC), in operation since 1974. Implementation was aided by the many blindness-related NGOs already at the country level. MOH invests much in training health workers, who then train district workers and distributors of the drug. Communities are involved in annual distribution. NGOs provide education and health-promotion activities in certain countries.

Measuring impact is still a challenge. Reporting goes to several sources, and partners like WHO and World Bank, pharmaceutical donors and intended beneficiaries all have different interests and reporting requirements. OCP and APOC are trying to measure impact, but find it very costly to do so. Operational research is difficult because there are no pre-research statistics. One of the
continuing challenges is how to ensure the destruction of expired drugs.

Jeffrey Sturchio
Botswana Comprehensive HIV/AIDS Partnership

(Powerpoint presentation available upon request)

Although it is a small country with a population of roughly 1.6 million, Botswana has the highest prevalence of HIV/AIDS in the world, with 38% infection rates among 15–49-year-olds. Valuable diamond mineral deposits and a lucrative mining industry make Botswana one of Africa’s wealthiest countries per-capita. The government, under the President’s personal leadership, has shown an unusual level of commitment to fight the AIDS epidemic, organizing a National AIDS council, a National AIDS Coordinating Agency (NACA), and multi-sectoral district councils to implement national strategies. “Our vision is an AIDS-free generation,” President Mogae has said.

The Bill & Melinda Gates Foundation and Merck & Co., Inc., have together committed $100 million over the next five years to support the government of Botswana in a comprehensive approach to sustainable solutions. They have sought a holistic approach, using the national program as a basis and integrating other programs therein; initiating this has required careful coordination. The Government of Botswana drives the program; their overall goal is to improve the entire country’s response to AIDS. They aim to implement basic, intermediate and advanced stages of care and treatment in a multi-pronged approach, using prevention programs, testing and counseling, condom distribution, home-based care, TB, opportunistic infections, and antiretroviral treatment, capacity building, expanded clinical expertise, and community mobilization.

The partnership has established a separate legal entity, the “African HIV/AIDS Partnership (ACHAP),” with a board including representatives from the Gates Foundation and Merck & Co., Inc. The Gaborone, Botswana-based project leader for ACHAP works in close collaboration with NACA. There is an international advisory committee, and various working groups among NACA and the local NGOs.

ACHAP and the Government of Botswana are working with several partners to implement Botswana’s plans. The Harvard AIDS Institute is providing training on HIV/AIDS for healthcare professionals. McKinsey is working pro bono on drug delivery issues. Merck is donating as much of its antiretroviral medicines, Crixivan® (indinavir sulfate) and Stocrin® (efavirenz) as is needed for the five years of the program; Botswana will use these drugs only where medically needed, according to established treatment guidelines Boehringer-Ingelheim (niraparip for preventing mother-to-child transmission) and Pfizer (flucinazole) will also donate their drugs for the partnership, and the Government of Botswana will procure others as required for the full range of treatment options. Measuring effectiveness is still a work in progress. For now, there are more questions than answers.
C. Presentations on Selected Public-Private Partnerships

How they are integrated into national health priorities and drug delivery systems

Marthe Everard
WHO/EDM, Drug Supply Strategies after Organizational Reforms

(Powerpoint presentation available upon request)

In low-income countries the credibility of the national health care system is largely dependent upon the provision of drugs in the health care services. The national drug procurement system, therefore, plays a crucial role in health care provision. Organizational reforms include transformations within ministries of health, the decentralization of central medical stores (CMS), the incorporation of competitive mechanisms within the public sector, and more involvement of private, for-profit and private, not-for-profit actors. Reforms were introduced to maximize benefit from both the public and private sectors.

The introduction of private management features into the CMS system is also an approach opted by some governments to improve the efficiency and quality of services. Another approach is the contracting out of services related to the provision of specific public services such as drug storage, transportation and distribution contracted to the private for-profit or private not-for-profit sectors.

The amount of centralization and privatization features introduced has to be viewed in each country’s specific context. Drug supply systems can range from central medical stores, to semi-autonomous supply agencies, direct delivery systems, primary distributors, and fully-private systems.

The conventional, central medical stores commonly face a number of constraints which undermine efficiency, but they may still have certain advantages. Central planning, pooled tendering and purchasing, quality control, and monitoring distribution are all important features. However, some of the alternate models can lower costs, increase access to essential drugs, and provide market incentives for competitive procurement and efficient distribution mechanism. The end-game question is: are patients and consumers better off?

Denis Broun
Essential Drug Franchising, Management Science for Health, Strategies to Enhance Access to Medicines (SEAM) Project

(Powerpoint presentation available upon request)

MSH conducted extensive assessments in several African countries to measure access to essential drugs (using indicators of availability, accessibility, affordability, quality, acceptability). Results of this measurement will be made public at the end of November 2001. Under the SEAM project, MSH has designed initiatives to trigger increased involvement of the private sector to improve access to essential drugs. Among these initiatives, the utilization of franchise has been studied and tested.

It was determined that a franchise model might work for essential drugs distribution—provided that the quality of products can be guaranteed—using the power of product branding to bring them to the public. Franchising has built-in incentives for market competitiveness and sustainability. The idea is to offer qualified entrepreneurs the chance to open drug shops on a franchise basis, where they put their own capital into the franchise (they may access loans for this purpose), and receive training and management support. Franchisees are closely monitored to ascertain they maintain high standards of performance and extensive record-keeping. They must pay a franchise fee, as a percentage of their annual turnover (revenues).

This franchise concept has been implemented in Kenya. After one and one-half years, the Kenyan
franchise has 26 outlets stocking 24 essential drugs, with a goal of 200 outlets within five years. Pooled procurement with MSH support enables these outlets to offer low prices.

Franchises operate on the basis of free market forces, and therefore certain social marketing programs or donation programs can seriously endanger their sustainability. For example, the sudden influx of donated insecticide-treated bed nets jeopardized demand from the SEAM drug franchisees to stock insecticide-treated bed nets. Private operators, who make a living of selling products from their outlets, cannot compete with donated goods and prefer not to sell these products at all. In the case of bed nets, the public health effect of this market distortion is likely to be the opposite of what was expected with the donation.

Mary Starling
Ruairi Brugha, LSHTM, Preliminary Fieldwork Experiences on GAVI

While the focus of this meeting was on drug delivery, it was felt that hearing an example from GAVI, the largest vaccine-delivery PPP, could be instructive.

The aims of GAVI include introducing under-utilized vaccines and systems-support into existing national health systems. A study funded by Save the Children UK examines how the process is being implemented in Ghana, Tanzania, Mozambique, and Lesotho. (Mary Starling and Ruairi Brugha emphasized that, as they had just returned, the information presented was preliminary.)

Interagency Coordinating Committees (ICCs) in each country include NGOs, donors, multilateral agencies and MOH, and are responsible for driving the application process. It is still early stages; Mozambique is the only country where vaccines have been delivered. Successful applicant countries are likely to be ones that are better off or better organized, which leads to the question of equity: what happens to the countries with poorer resources for meeting the requirements for GAVI support?

The application process was perceived as time-consuming, with high opportunity costs for senior MOH officials. The deadlines were perceived to be tight. In some of the countries visited, the burden of disease for Haemophilus influenzae type b (Hib) was not known and therefore the vaccine was seen as a lower priority than preventing and treating diseases such as HIV/AIDS. Data collection presents a constant challenge, as it is very difficult and there is so little confidence in the figures reported in many countries. Careful thought must be given to providing workers with incentives for accurate numbers, and to holding them accountable.
The broad aims of the meeting were to share views and experiences regarding how PPPs in the health sector ‘play themselves out at the country level,’ particularly those partnerships involving drug delivery and distribution. More specifically, we aimed to identify and discuss the value-added achieved by such partnerships, the costs associated with them, and their unintended consequences for health systems in developing countries.

The following summarizes nine major themes that emerged from six diverse presentations, as well as the discussion of issues around measuring impact and effectiveness, the integration of PPPs into national health systems, and broader research questions raised by the advent of PPPs. The six presentations provided overviews of specific PPPs; of experimentation with a novel mechanism to involve private providers in rational drug use; and an overview of drug distribution systems at the country level.

1 The meeting participants acknowledged that the terms ‘partnership’ and ‘public-private partnership’ are presently used in a non-discriminating fashion, and that sensible discussion and analysis require common understanding and greater specificity as to the unit of analysis. There were, however, divergent views as to whether critical attributes of public-private partnership involved simply ‘an agreement among public and private actors to achieve shared goals through a mutually-agreed division of labor’ or, rather, that ‘their governing structures exhibit some degree of shared decision-making.’

Although this meeting focused on partnerships involving private commercial partners, it was stressed that civil society often represents a critical but overlooked aspect of successful public-private partnership. Another critical element discussed: ‘true’ public-private partnerships involve outcomes that could not be achieved by either sector acting alone.

2 Analysis of the impacts of PPPs at the country level should involve a range of criteria beyond effectiveness, value-added and costs, it was proposed. In particular, a range of anecdotal reports of unintended consequences suggest that further analysis and appropriate evaluative criteria should, and perhaps should, include equity; participation/representation of constituencies affected by PPPs in decision-making bodies; ring-fencing of the public processes of norm- and standard-setting from commercial interests involved in public health programs through specific partnerships; transparency; accountability to multiple constituencies; and sustainability, among others.

3 Even after adopting a narrow definition, PPPs assume many different forms; it follows, then, that there is probably not one model or standard approach to evaluating their impact at the country level. One critical parameter concerns the perspective(s) from which we make assessments. It was proposed that it is the responsibility of the partnership entity itself to measure progress against the goals and objectives it has set; this should include, among other things, an assessment of the impact of the partnership on changes in health status. It was suggested, however, that this is complicated because: (1) goals and objectives are sometimes vague and not agreed to by all partners; (2) baseline data are often poor or non-existent; and (3) attributing the partnership’s specific contribution to health program outputs and/or health outcomes can be exceedingly difficult. Moreover, as alluded to above, this approach to assessing impact is far too narrow, specifically as it fails to consider potential costs from a variety of perspectives.

There was particular concern that greater emphasis tends to be placed on identifying the ‘win-win’ dimensions of PPPs and too little on potential negative externalities. Both ex ante and during monitoring, commercial entities appear to pay a
great deal of attention to their contribution or value-added in terms of the volume of product shipped and of treatments administered. It also appears that UN organizations pay increasing (but quite variable) attention to the mission-alignment and costs of their involvement in specific PPPs. In contrast, there may be a systematic bias toward identifying and measuring the value-added gained through partnerships (particularly since these might accrue more rapidly), in contrast to identifying and quantifying the potential negative costs of partnerships.  

**Examples of the value-added gained through partnership were enumerated.** In summary:

- Additional drugs, supplies or funds (that would not otherwise be available);
- Coalition-building at the country level (particularly with civil society);
- Impetus to new thinking and approaches;
- Provision of new skills, particularly management;
- Improved monitoring and surveillance of health problems;
- Better understanding of health problems through targeted operational research;
- Strengthened capacity of health workers;
- Higher profile of specific health problems on national and international agendas;
- Public health efforts are piggy-backed on existing private-sector distribution and advertising systems; and
- Wider use of accepted best-practice guidelines and strategies.

**Examples of the costs associated with PPPs were enumerated.** In summary:

- There are potentially significant opportunity costs associated with involvement in PPPs. Although organizations such as the World Bank practice a great deal of selectivity due to these costs, at present there is relatively little emphasis on identifying and valuing these costs at the national level;
- Attention and resources can be diverted from national priorities (however, the when done well, PPPs support, rather than subvert, national priorities);
- Existing drug- and other distribution systems may be distorted;
- Parallel and duplicative systems are established for surveillance, delivery, monitoring, etc.;
- Normative functions of public-sector agencies are “captured” (or unduly influenced, e.g., in the development of best-practice guidelines or formulary lists);
- Equity within and between countries and population groups may be upset;
- Patients travel across borders to take advantage of free, cheaper or better services.

**Many of the potential costs and unintended consequences are neither particularly new nor unique to public-private (commercial) interaction at the country level, it was acknowledged. In particular, many similar problems continue to beset public-public collaboration (i.e., traditional development cooperation) and public-NGO collaboration. Greater attention to PPPs may simply serve to highlight tensions in development cooperation and national health development. Nonetheless, regardless of whether these problems are unique to PPPs, they should be better identified, measured and valued, to properly assess their potential and actual impact when deciding whether a proposed PPP is appropriate and how it should be structured.**

**A number of steps might facilitate the identification and mitigation of some of the negative externalities, including:**

- Earlier in the process of partnership development, involving ‘beneficiaries’ and other local constituencies who might be negatively affected (e.g., competing national health programs);
- Putting the Ministry of Health in the driver’s seat;
• Including PPPs in long-term dialogues on national health development, national health planning and budgeting, and sector-wide approaches, where appropriate;
• Placing greater emphasis on the process indicators relating to ‘partnering.’

8 ■ There are at least two features distinguishing PPPs from traditional development cooperation. First, they involve a new generation of ‘donor’ (i.e., commercial and foundation) that expects relatively fast and visible results (this may be a quantitative distinction). Second, the private and public sectors are fundamentally accountable to distinct (if sometimes overlapping) constituencies. Consequently, PPPs raise a different set of questions relating to governance issues.

9 ■ If the potential of PPPs is to be maximized, and possible negative consequences minimized, then greater attention must be paid to the manner in which PPPs are integrated into national health programs, and to the consequences of this integration. A number of proposals and approaches for further research were discussed:
• Comparative analysis across partnerships on specific obstacles to implementation, integration, management, etc., and how they have been addressed, in order to facilitate cross-learning;
• Comparative analysis across partnerships on how they have dealt with potential negative externalities (e.g., how have they ring-fenced normative and stewardship functions, managed conflicts of interest, etc.);
• Case studies on decision-making processes within specific PPPs (which could include the time involved in various processes, cultural issues);
• Case studies of the organization and management of specific PPPs to illustrate noteworthy examples of added-value or to display negative externalities, so as to learn what works and what does not;
• Analysis of the impact of PPPs on national policy making;
• Analysis of the impact of PPPs on international health agendas and on the multilateral system;
• Analysis of policy transfer through PPPs from global to national and back.

Presentation at Forum 5
At Forum 5, on 11 October, Dr. Louisiana Lush, a representative from the London School of Hygiene and Tropical Medicine, presented her perspective of the London meeting during a parallel session on Public-Private Partnerships: Emerging Issues. As Dr. Lush stated, her presentation reflected her professional viewpoint; she developed it immediately following the meeting and so did not have input from other attendees. It did not represent an official summary of the meeting, but rather one participant’s reflections. Nevertheless, the presentation was seen by many to capture the essential issues that were discussed, although this was not universally agreed. One participant expressed the view that the presentation was negatively biased and that the focus on heavy transaction costs was not representative of the meeting. (PowerPoint presentation available upon request.)
New strategic global health alliances have arisen when the traditional relationships between the public and private sectors could not meet the challenges of neglected diseases or conditions. While PPPs may be social experiments, it appears that the trend for the growth of PPPs will continue, at least in the near future. However, a possibility exists that some PPPs may merge due to perceived synergies, while others may disappear for lack of success or funding. The competition for possibly fewer donor funds due to global economic uncertainties may spur increased scrutiny on the effectiveness of PPPs. Also, PPPs are facing greater pressures for early successes by the new classes of donors funding them (private foundations and social venture capitalists used to private sector levels of accountability and transparency).

Two obvious criticisms of PPPs are: 1) the lack of hard evidence about whether they add value and 2) their seemingly vertical approach and the challenge they pose for integration into existing national priorities and health delivery systems. Our concern as researchers is how to measure both the efficiencies and the downsides of partnerships, and to suggest improvements. While it is important to include process, anecdotal and case study analyses, can we also be evidence-based? What data do we need in order to measure this and how can we collect it? How can we be sure we are comparing ‘apples to apples’ and not ‘apples to pears’? It was noted by participants that the perceived value/benefit and risks of partnership varies depending on the perspective of each partner, primarily based on to which sector they belong.

While attention is naturally focused on dissecting and understanding this new phenomenon, the PPP, some attendees pointed out that the same questions need to be asked of the traditional, public-initiated approaches to neglected disease problems as well. In order to make a comparison with PPPs, we must also examine the same transaction costs, unintended consequences, and health outcomes or achievements associated with SWAs and other government-led programs. Many of these issues are the perennial topics of debate in public health and apply equally to public-based programs as to the trend-setting PPPs. Any coherent analysis of the relative quality and effectiveness of different methods requires a balanced assessment of the value added versus costs incurred in both.

Measuring effectiveness: Specific research questions

1. How does each partnership currently measure or plan to measure its effectiveness?
2. Do they have reliable baseline data? Have they apportioned resources to collect the baseline data, to implement monitoring and performance evaluation?
3. What are the objectives? Are they quantifiable and measurable?
   - Number of patients reached? Coverage of population?
   - Percentage of disease burden reduced?
   - Number of drugs/vaccines/health products distributed?
   - Number of facilities, training programs, etc.?
   - Other quantifiable measurements and indicators?
4. What qualitative factors and process indicators should be tracked?
   (Some participants asserted that is entirely feasible to construct, validate, and interpret indicators in respect of capacity building and systems strengthening.)
5. Can the program’s future health benefits be estimated?
6. What reporting is requested by donors, partners, stakeholders?

7. How important/valuable is it to be able to develop an effective performance evaluation system?

8. Is it realistically possible to measure the value-added, less any negative impact?

**Value-added/benefits of PPPs**

+ Building new cross-sectoral coalitions (particularly with civil society at the country level).
+ Tapping into new donor sources, beyond traditional bilateral sources.
+ Through focused efforts, effecting needed change that current public systems could not otherwise achieve.
+ Providing drugs to segments of society that MOH does not reach, thus freeing MOH to focus on the poor who are more easily reached.
+ Bringing new skills to the public sector; introducing more discipline and a business-like approach to public health management practices.
+ Encouraging the private sector to act in a more socially responsible manner; to learn about potential new markets; to justify continued industry R&D into neglected diseases of the poor.

**Negative factors/risks of PPPs**

- In some cases, high transaction costs to integrate each new vertical disease program into MOH national plans place excessive burdens on MOH resources. At what point do their burdens to countries outweigh their worth? Note: some participants objected to this phrasing—see below)
- Overhead for each ‘vertical’ PPP directs resources into international secretariats, staff. How do secretariats justify the investment versus injecting into the country level?
- Allowing public health authorities to delegate responsibility and outsource to PPPs. Does this abdicate health technical authority? Does it impinge on the normative function of WHO, MOH, and other public health interests?
- Health inequities could worsen if patients who can pay are the only ones to reap the benefits, or if programs go only to those countries that are organized well-enough to entice partnership involvement (e.g. Botswana for AIDS support, or qualifying countries for GAVI vaccines).
- Global decision-making, rather than involving the national framework from the earliest point. PPPs have usually started at the international level (top-down approach) rather than from the bottom up.
- Trans-border leakage problems (if PPPs offer drugs/services in one country and not in adjacent countries).

Public programs should be scrutinized as well: Some participants maintained that we cannot presume that resources invested in countries through disease-focused or other PPPs would necessarily be committed to sector-wide approaches or purely government-led initiatives. Many donors have been dissatisfied with the use of funds contributed to recent basket approaches and the poor accountability, transparency, or results associated with some public sector programs. Groups concerned that PPP’s incur high transaction costs should look at the alternative—what is the efficiency factor and track record of money spent in SWAs or purely government-led programs? Also, we cannot presume that national priorities are always necessarily reflective of the needs of the groups that PPPs are often attempting to serve. Seldom do those suffering the most from neglected diseases have a voice in setting national health agendas.

**Integration into national systems and priorities: Specific research questions**

1. Regarding the problem of integrating disease-specific PPPs into national priorities and existing systems: how should this be chronicled? Case-by-case, cross-disciplinary approach?

2. Are these tensions the same as those existing between vertical disease programs and sector-wide approaches (SWAs)? Or are there new dynamics involved? Does involvement by the private sector aid or abet the integration process? How do we move beyond ‘business as usual?’

3. New PPP initiatives enter countries as indi-
vidual programs, offering products, services and funding to MOHs. How many new programs can a country handle and try to integrate? How effective are interagency coordinating mechanisms in pooling this process?

4. What are the primary obstacles to integration? What factors improve perceived integration by PPPs? How do you measure integration objectively?

5. How can globally-organized programs effectively bring in the MOH and country-level perspective right from the start? If not onboard from the beginning, how can they effectively be brought in mid-stream?

6. What kind of training is needed to bridge organizational culture gaps between private and public sector partners in PPPs?

Additional themes and questions raised in discussions

Public health segmentation
Within the context of national priorities, what is the added value of PPPs? Can market segmentation for the delivery of health services be a value in itself? In some cases, PPPs could provide drug delivery to areas that the MOH public programs cannot reach. If PPPs can address certain needs, this frees the MOH to focus on and address other areas. MOH needs to think about “make vs. buy”: what can they do themselves and what could they more efficiently “subcontract” to others?

Normative capture
Some in the group felt that when the private sector is increasingly involved in PPPs for health, this may constitute “normative capture,” impinging upon the authority of national public health to set priorities and implement programs. The concerns raised: commercial objectives would exacerbate health inequities; too little national input is included; sustainability is jeopardized for short-term results; too little technology transfer occurs. Others pointed out that these issues arise in traditional bilateral aid programs and national public health programs as well, and are not unique to PPPs. Awareness of the issues and transparency in implementing new programs are the best ways to ensure that PPPs support, rather than subvert, national health priorities.

Time commitment
How is measurement affected by partnerships’ time horizons? Gates seems to favor five-year profiles. New donors like Gates, Soros, want to see quick results, and are focused more on accountability than are public funding sources. But do quick results take into account the long-term perspective needed for country development? Others in the group asked: why complain about Gates’ five-year commitment? When did traditional bilateral funders ever commit for so long? This begs the larger question of how partnerships look at sustainability and possible exit strategies.

Delivery and new products
Getting currently-available drugs to intended beneficiaries is as much of a challenge (if not more) as developing new drugs to combat neglected diseases. Product development partnerships must begin thinking about these issues from the beginning. For example, imagine the frustration if IAVI came up with an AIDS vaccine too quickly? Research-based industry is highly motivated by the idea of a product reaching the actual patient. If global public health could solve the delivery issue, it would achieve full industry support on investments in new products.

NGOs role
How important are NGOs to these partnerships at ground level? (For Mectizan and ITI, they are extremely important.) At what point in the life cycle of a partnership do they become important? What must be studied in order to enhance performance in this area?

Replicability
Participants discussed the importance of replicability—that PPPs, as a new way of working, represent an opportunity to learn how to develop structures/processes that can be easily replicated (or even “franchised” like the provision of essential drugs in the SEAM project) so as to reduce start up costs and the steepness of the learning curve.
Annex: List of attendees

• **Aboagye-Nyame, Francis** – Ministry of Health (Ghana) – Ag. Head, Procurement Unit

• **Asiama, Divine** – Ministry of Health (Ghana) – Program Manager Ghana National Drug Program

• **Broun, Denis** – Management Sciences for Health – Principal Program Associate and Global Liaison

• **Brugha, Ruairi** – London School of Hygiene and Tropical Medicine – Senior Lecturer in Public Health

• **Buse, Kent** – Yale University School of Medicine – Professor

• **Cook, Joseph** – International Trachoma Initiative – Executive Director

• **Everard, Marthe** – WHO – Technical Officer: Policy, Access, and Rational Use (PAR) / Essential Drugs and Medicines Policy (EDM) (Serving as WHO resource person to meeting)

• **Harden, Anita** – University of Amsterdam – Professor

• **Heaton, Annie** – Save the Children – Research Analyst, private sector

• **Holm, Karin** – Initiative for Public-Private Partnerships for Health – Senior Program Officer

• **Kettler, Hannah** – Biotechnology Foundation; Institute for Global Health – Project Director

• **Kevany, John** – Trinity College Dublin – Dept. of Community Health

• **Lush, Louisiana** – London School of Hygiene and Tropical Medicine – Lecturer in Health and Population Policy

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• **Starling, Mary** – London School of Hygiene and Tropical Medicine – Research Assistant GAVI

• **Sturchio, Jeffrey** – Merck & Co., Inc. – Executive Director

• **Walt, Gill** – London School of Hygiene and Tropical Medicine – Professor of International Health Policy

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