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Are the global health partnerships we have the partnerships we need?

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Abstract

Partnership is essential for solving complex global challenges. In global health, however, partnership has become associated with a specific model: public-private partnerships (PPPs) in which the key actors are donor governments, philanthropic foundations, and the private firms that produce drugs and vaccines. As this model comes under strain in the face of cuts to international aid and criticisms of the lack of transparency and accountability in some of the biggest global health PPPs, we should look not only to make incremental reforms but also to engage in more fundamental questions about the kinds of partnership we need to tackle current and future global health challenges. This involves thinking about who the appropriate partners are for particular purposes, and what we want these partnerships to do. Although it may be tempting to respond to the current difficult context for global health by doubling down on the PPP model, trumpeting its successes and downplaying the more difficult questions, inertia will not produce the solutions we need to drive an ambitious post 2030 agenda.

Contributors

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Introduction

Partnership is essential for solving complex global challenges. In global health, however, partnership has become associated with a specific model: public-private partnerships (PPPs) in which the key actors are governments, philanthropic foundations, and the private firms that produce drugs and vaccines. In the early 2000s the PPP blueprint became the go-to model for new global health institutions, exemplified by the Global Fund to Fight AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance. Yet today, both are facing tough replenishment rounds. Aside from the threat to US aid spending posed by the election of Donald Trump, other major donors have also made massive cuts in their 2024 ODA budgets, including France (-$808 million), Germany (-$2.2 billion) and the UK (-$1.9 billion).[1] There are also persistent and unaddressed concerns around the legitimacy, transparency and accountability of institutions based on the PPP model.

The current context brings real dangers in terms of the sustainability of current global health initiatives. To address these challenges, we argue that reform proposals put forth after COVID-19 need to be implemented. But they need to be the start, not the end, of a conversation to rethink the models of partnership needed to drive an ambitious post 2030 global health agenda.

The 'PPP blueprint' and its unintended effects

Gavi and the Global Fund are the largest and most influential PPPs in global health. Created to address specific health challenges by expanding access to pharmaceutical products, they promised more inclusive ways of managing funding flows by offering joint decision-making to a multitude of stakeholders.[2] They claim to embody private sector principles of efficiency and transparent reporting, and focus on financial and technological innovation to deliver in saving more lives.[3] Over two decades, they have become increasingly powerful players in global health,[4] channeling $8 billion, or 12.4% of the total ODA budget for health worldwide, in 2023.[5] Their success has been seen in vastly increased immunization coverage (Gavi) and expanded access to treatments for HIV, TB and malaria (Global Fund). In addition, they have played an important normative role in defining the appropriate relationships between the public and private sectors.[6] Their model became the blueprint for a range of recent institutional innovations including the Access to Covid-19 Tools (ACT) Accelerator, the Coalition for Epidemic Preparedness Innovation (CEPI), and the Pandemic Fund.[7]

The success of the PPP model, however, has had unintended consequences for the wider global health landscape. While successful at reducing deaths from certain infectious diseases, the vertical focus of PPPs has fragmented and weakened recipient countries' health systems.[8] They have (inadvertently) diverted limited resources and staff to support their own priorities, imposed significant administrative burdens due

[1] Seek donor tracker
[2] Rushton & Williams (2011); Harman and Papamichail (2024); Schäferhoff et al (2009)
[3] Clinton and Sridhar 2017
[4] de Bengy Puyvallee (2024)
[5] IHME https://vizhub.healthdata.org/fgh/
[6] Rushton and Williams (2011)
[7] Storeng, de Bengy Puyvallee & Stein 2021; de Bengy Puyvallee 2024
[8] Storeng 2014; Birn 2005; Buse and Harmer 2007

to complex and overlapping reporting requirements, and potentially disincentivized domestic health financing.[9] Their preference for technological (especially pharmaceutical) interventions that deliver easily quantifiable returns on investment has overshadowed more complex systemic interventions that might be needed to address deeper structural issues.[10]

The PPP model has also led to profound accountability and conflict of interest problems. PPPs effectively provide public subsidies to commercial companies in an attempt to address so-called market failures, creating demand for commodities that are otherwise unaffordable for those who need them and promoting pro-poor innovation. Yet, the private actors involved in these PPPs are not only suppliers but are partners. With that comes considerable influence over funding and strategy, both directly (through seats on the Board) and indirectly (through various lobbying/political advocacy activities).[11] During Covid-19, for example, global health PPPs de-risked pharmaceutical industry investments without imposing sufficient contractual provisions for equitable access, allowing them to privatize the gains.[12] Their commitment to voluntary principles for partnership also played a role in foreclosing policy alternatives, such as a temporary waiver on intellectual property rights.[13]

The expansion of the PPP model has also further entrenched the hierarchical relationship between donors and recipients. While "implementing countries" are represented in PPPs' governance structures, their charity-based funding model compels them to align with the priorities of a handful of sovereign and philanthropic donors. Consequently, they have been criticized for fostering dependency relationships based on ever-changing donor agendas rather than establishing sustainable systems that reflect the needs of recipients.[14]

Although some PPPs have attracted significant funding from private foundations, most notably the Gates Foundation, the original promise that they would tap into new sources of private sector financing have remained unfulfilled: in the case of the Global Fund, for example, 94% of its funding comes from taxpayers in donor countries[15]. This leaves partnerships as vulnerable to the unpredictability of donors as non-PPP models, and undermines one of their key claimed advantages as compared to purely public institutions.

Proposals for incremental reform

25 years after their launch, and in part in response to these challenges and criticism, we are now seeing renewed discussion about the future of global health partnerships. The most prominent reform effort is the Lusaka Agenda which calls on global health partnerships to make a bigger contribution to strengthening systems for health through integrated delivery of services and aligning behind one national health plan, while also catalysing domestically-financed health services and public health functions. The Lusaka

[9] Nonvignon, Soucat, Ofori-Adu & Adeyi (2024); Witter et al (2023)
[10] Birn 2005
[11] Rushton and WIlliams 2011; Buse and Harmer
[12] Stein 2020 Risky business
[13] Kavanaugh and Singh 2023; Storeng et al 2021
[14] Buse and Harmer 2007, Nonvignon et al 2024
[15] Clinton and Sridhar

Agenda calls for "accelerated" efforts to address "power imbalances" within these organizations, and to better align with the priorities of implementing partners.[16]

The Lusaka Agenda provides a useful roadmap, which needs to be taken seriously by these organizations' secretariats, and followed-up by their boards, and particularly their donors. Some steps have been taken in the right direction, such as initiatives to increase cooperation between partnerships, and the promise to "democratize" Gavi made by its new CEO, Sania Nishtar.[17] However, this reform agenda has strong echoes of past failed initiatives such as the Three Ones in the global HIV/AIDS response and the Venice Declaration (2009). The launch of another PPP, the Pandemic Fund, suggests that the Lusaka Agenda and others' calls to halt the proliferation of such partnerships have not been heard. We also need to find ways to strengthen the public-interest leadership of PPPs, including by formulating clearer expectations regarding private partners' behaviours, holding them accountable when they breach their own voluntary commitments, strengthening contractual clauses, and increasing transparency requirements.

The need for a wider conversation about partnership

The PPP model is now so ingrained that none of the current proposals for incremental reform question whether these are the right kinds of partnership for global health. It is possible that incremental efforts may constrain our ability to think creatively by limiting the conversation to the partnerships we *have*, rather than discussing what partnerships we *need* to pursue an ambitious post 2030 agenda.

We need to recognize that the existing global health partnerships have had a tremendous impact by normalizing and legitimizing the role of private actors in global governance, including philanthropic foundations and multinational corporations. This has had ripple effects: the WHO, for instance, increasingly adopts elements from the partnership playbook, mimicking their replenishment model with its first "investment round"[18] and launching the WHO Foundation to attract private capital.[19] We should not uncritically assume that partnering with mega philanthropic foundations and the for-profit sector is the right model. Instead, we need to start by identifying what health challenges we want to address, and from there think about the right mix of partners for dealing with them.

For example, the PPP model may not be the best for addressing the social and economic determinants of health; health systems strengthening; the health impacts of climate change; or the growing global burden of non-communicable diseases (NCDs). To take the example of NCDs, which now make up 74% of the global burden of diseases,[20] the private sector is part of the problem.[21] Effective action requires reducing corporate influence, not increasing it, to open up the political space for more regulation and/or increased taxation of health-harming products like tobacco, alcohol and unhealthy food[22].

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[16] Lusaka agenda https://d2nhv1us8wflpq.cloudfront.net/prod/uploads/2023/12/Lusaka-Agenda.pdf
[17] Usher 2024 https://www.development-today.com/archive/2024/dt-5--2024/gavis-new-ceo-asks-for-usd-9-billion-from-donors-promises-to-democratise-organisational-culture
[18] De Bengy Puyvallee and Storeng 2024
[19] Ralston et al 2024
[20] Investing in health report
[21] Maani, Petticrew and Galea 2023
[22] Maani, Petticrew and Galea 2023; WHO best buys 2017

Aside from asking who the partners should be, we also need to ask what partnerships should do. The most prominent existing PPPs are vehicles for investing in health commodities. But we need other forms of financial and political investment too if we are to address the root causes of ill-health, such as poverty, social injustice, or war and violence.[23] Addressing these broader political determinants of health requires partnerships based on cross-sectoral alliances to push back against the deleterious effects on health of austerity, the looming debt crisis and tax avoidance, all of which hugely undermine countries' ability to resource their own health systems and programs[24]. Here the partners we need might be many and varied, including strong civil society coalitions, like-minded governments, independent research organizations, and public-interest journalists.

One response to the current challenges global health institutions face would be to double down on the PPP model: to trumpet its successes and downplay the more difficult questions in a desperate attempt to keep the money rolling in. Falling into this 'replenishment trap', however, would be a mistake. Instead, we should rebuild our current understanding of partnership from the bottom up to deliver the global health partnerships we need, not just those we have.

[23] Ottersen et al 2014; Agyepong et al 2023
[24] Ottersen et al 2014