

Resourcing and access: The role of cross-sector partnerships

Lord Paul Boateng

I well remember a proverb from my school days in Ghana: 'It is each and every feather that makes the eagle soar.' This reference to the unique qualities of size, weight, placement and function of every element of that great bird's plumage working together has remained fresh in my mind all the long years since. More than that, this central truth of the need for varied but co-ordinated action from a diversity of elements to achieve successful implementation was reinforced subsequently by a ministerial career in the UK, which spanned health, policing and the Treasury. Win some, lose some! But success or failure in policy delivery terms is, in my experience, usually determined by the quality of the partnerships that are able to be brought together around a shared and jointly owned objective.

The fact that, globally, we have witnessed such remarkable progress in recent years in reducing childhood disease and improving infant mortality is not down to any one single solution but rather a number of different factors and players combining together in effective partnership. It is because of such partnerships that we are now seeing fewer people developing and dying from AIDS-related illnesses, and the number of cases of malaria and tuberculosis falling. It is through integrated approaches that we have made advances in nutrition and enabled more people to have access to clean drinking water and sanitation. And it is through partnerships in immunisation that we have seen the number of deaths of children under five fall from 12.6 million in 1990 to 6.6 million in 2012.

I have been privileged, as a global ambassador of the GAVI Alliance, to see just how cost effective a health intervention immunisation is. Not just impacting on mortality rates but by significantly reducing illness and long-term disability in both children and adults, reducing the burden of disease on families, health systems and society as a whole. I was in cabinet as Chief Secretary to the Treasury in the UK when we pioneered and launched the International Finance Facility for Immunisation. This was, at the time, seen as revolutionary in its use of global financial markets for the achievement of a public good and has since proved to be a particularly successful funding mechanism. We need some equally radical and innovative thinking around funding the next generation of MDGs in a resource-constrained global environment. If the nation's health is to benefit from these, health ministers and their departments need to be part of that early thinking.

GAVI, itself founded earlier in 2000, brought together for the first time in this unique way public and private sector donors, research expertise from both academia and industry, and civil society

advocacy – all underpinned by political engagement at every level. Ghana and Tanzania have demonstrated the unique benefits of this partnership approach. In both countries, GAVI – working alongside local delivery partners, including traditional grass-roots and civil society leaders as well as local and central government – has assisted in enabling the dual launch of pneumococcal and rotavirus vaccines. In the process, they have overcome cold chain, and other planning and communication challenges to protect children in even the most remote rural communities from pneumonia and diarrhoea, the two biggest killers of children under five.

The Kilifi district of Kenya saw the number of hospital admissions due to pneumococcal disease from vaccine serotypes fall from 38 to zero within three years of the launch of pneumococcal vaccine.¹ Recent research has shown that children in Bolivia who have been vaccinated against rotavirus are 70 per cent less likely to be hospitalised for rotavirus diarrhoea than unvaccinated children.²

Similarly thanks to GAVI, the expansive roll-out of pentavalent vaccines, which combine diphtheria-pertussis with vaccines that protect against hepatitis B and Haemophilus influenzae type B (Hib), has helped boost the coverage of routine immunisation significantly. In 2012 as many as 66 per cent of World Health Organization (WHO) member states had reached at least 90 per cent coverage of routine immunisation. Global measles immunisation coverage had reached 84 per cent amongst children aged 12–23 months, with the number of deaths decreasing in the previous decade by 71 per cent, from 548,300 in 2000 to just 157,700 in 2011.

And, given the unprecedented demand GAVI has had since it started making human papillomavirus vaccines available last year, we should expect to see cases of cervical cancer falling in the years to come as well.

There is no room for complacency however. Nigeria has one of the highest numbers of vaccine preventable deaths in Africa, with 756,000 children dying from diarrhoea and pneumonia in 2011 alone. Part of the problem is gaps in Nigeria's supply chain. The absence of cold chain equipment to keep vaccines cool has proved to be literally fatal. And for many children, data as to what vaccines they have or have not received is simply non-existent. I have witnessed for myself the pride a mother can take in showing off her child's up-to-date health records. This is truly the difference between life and death for so many less fortunate children and their mothers. Without data, health care systems run blind, waste is prevalent and it is impossible to predict shortages.

India too has its challenges. The subcontinent is home to a third of the world's unimmunised children. Yet, good news! It has been three years last January since India's last reported case of wild polio and the country has now been declared officially polio free by the WHO. This is not an inconsiderable achievement. Nigeria too is fighting back against the polio virus with a Private Sector Health Alliance and an exciting combination of philanthropists, CSR actors and traditional leaders taking up the battle against polio. Kano is showing the way and Lagos too is mobilising new resources in the fight to save lives. Health ministries in Africa now need to look to the mobilisation of private local philanthropic resources in health promotion. African resources applied to meet African challenges. I have every reason to believe that a new generation of African wealth creators is emerging and we need them to partner with governments and global agencies in public health promotion. This new generation of entrepreneurs is able and willing to act.

Co-financing and a new emphasis on the generation of local resources, at a time of global pressure on resources across the board, is here to stay in health care as in so many other areas of activity. As we look to the future and the next generation of development goals post-2015, it has never been more important to build effective partnerships for change. This must involve closer working between health and finance ministries to make the case and develop the mechanisms for both preventative and cost effective health and social care interventions.

There are new challenges with associated costs around ageing and mental health, where the boundaries between health and social care are blurred. We have a saying in West Africa: the cook that starts early breaks more pots. Those coming later to the task need not be doomed to repeat the errors of those who came earlier. We all need to share experiences of what has and has not worked, while respecting the need for home-grown and culturally appropriate solutions.

There are also costs from new developments in medical science, growing prevalence and awareness of some conditions, and an ever more demanding and informed electorate and consumer. The hepatitis C virus (HCV) infection, for example, is a growing concern with an estimated 185 million people infected globally. Untreated, it can cause cirrhosis, liver failure and liver cancer, claiming 350,000 lives each year from complications. Many national governments have not identified HCV as a strategic priority. Scotland is one of the few nations to have heeded the World Health Assembly May 2010 call for concerted action at a national level, developing and fully funding a well-functioning strategic national plan.

England lags behind in this regard. Access to the newest generation of HCV medicines will be critical. They have the potential to offer a cure with significantly simplified treatment regimes. These developments come, of course, with a price tag. All the more reason for the conversation to begin now, within government, and with the pharmaceutical industry and clinicians,

to develop a concerted and co-operative approach to this issue and others that are on the horizon. Emerging economies and nations can't put this to one side in the hope that it will go away. The move by one key player in the pharmaceutical industry to licence their new HCV treatments to Indian generic manufacturers, with the ultimate aim of reducing prices for a global market and stimulating generic competition, is significant. We must surely apply the lessons learnt from the global response to HIV to new global health challenges, including HCV. We need policy solutions and funding mechanisms that promote public-private partnerships in delivering equitable health care the world over.

This will involve building human and organisational capacity. Science technology and innovation will, of necessity, move up the development agenda. South-South co-operation too will become of increasing significance. The links between South Africa, India and Brazil have wider regional implications for their respective hinterlands and are already beginning to make an impact in health-related areas. We are entering an era of unparalleled opportunity. Our success or otherwise will depend upon the quality of the partnerships we build as the drive is on to enhance capacity in medicines, health services, agriculture and nutrition, and public administration. We need a 'smart government' response to these new developments. This will require health departments to work within government with the departments of education, agriculture and industry in new ways properly resourced by finance ministries. These will need to focus on cost-effective investment to promote productivity and well-being, with public health, preventative medicine and private sector involvement given a new impetus.

Flight is a complex business, as the proverb of the eagle and its many different feathers reminds us. So too is the nation's health. But when we all do manage to work together across the boundaries of the public and private sectors, and across our different departmental boundaries, the results are likewise a wonder to behold.

Endnotes

- 1 See: *The Pneumococcal Conjugate Vaccine Impact Study* by Anthony Scott. Available at: www.kemri-wellcome.org/index.php/en/studies_inner/75 [Accessed 14 April 2014].
- 2 Patel, M. M., Patzi, M., Pastor, D. et al., 2013. 'Effectiveness of monovalent rotavirus vaccine in Bolivia: Case-control study'. *British Medical Journal*, 346, f3726.

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Three public–private partnerships in global health

Christer Jönsson*

GAVI

GAVI was established in 2000 with a US\$750 million donation from the Bill and Melinda Gates Foundation. It was a joint initiative by Bill Gates and the leaders of WHO, UNICEF and the World Bank. Its goal was to increase the level of child immunisation in poor countries through funding the deployment of vaccines and providing incentives for developing new vaccines. GAVI is governed by a board, where two-thirds of the voting members represent partner institutions and stakeholders, and one-third are unaffiliated individuals appointed in their personal capacity. Pharmaceutical companies are represented on the board.

GAVI has been successful in raising the levels of child immunisation at an unprecedented rate. By 2009, some 50 million children had been protected with basic vaccines and more than 200 million with new and under-used vaccines. By its own estimates, GAVI has contributed to the prevention of 3.4 million future deaths. GAVI has been less successful in encouraging the development of new vaccines and reducing vaccine costs. The Bill and Melinda Gates Foundation has contributed more than \$1.5 billion over fifteen years, which makes it the largest single donor, accounting for 28 per cent of GAVI's total funding. However, few other private donors have followed the foundation's example and national governments continue to make up the majority of donors.

The Global Fund

The Global Fund was established in January 2002 as a grant-making organisation with its secretariat in Geneva. It functions in a way similar to research councils or foundations in the academic realm insofar as proposals are subjected to peer review, grants are awarded to a fraction of the applicants for a limited period of time and renewed grants are contingent on documented performance. At the insistence of some G8 countries, especially the USA and Japan, the Global Fund was to stand apart from and operate outside of the UN system, which was considered inefficient and bureaucratic. In its ten years of existence, it has disbursed over \$9 billion to grant recipients.

The hybrid character of the Global Fund is reflected in the composition of its board. It consists of five types of constituencies: donor states, recipient states, civil society, private sector, and bilateral or multilateral agencies. Three civil society representatives (one North, one South and one affected community) and two representatives from the private sector (one company and one foundation) sit on the board. The Bill and Melinda Gates Foundation, as a major contributor, has the foundation seat on the board. Interestingly, representatives from WHO, the UN Joint Programme on AIDS (UNAIDS) and the World Bank belong to the non-voting group, an unusual position for intergovernmental organisations.

UNITAID

Efforts to develop innovative mechanisms to finance health development have continued. France and Brazil, in particular, have taken initiatives to improve access to medicines for the world's poorest people. Along with Chile, Norway and the United Kingdom, they created a partnership in 2006 called UNITAID, which is designed to collect funds through levies on airline tickets to finance medicines against HIV/AIDS, tuberculosis and malaria. As of this writing, UNITAID has 29 member countries, nine of which are implementing the airline levy. Norway allocates part of its tax on CO₂ emissions from aviation fuel to UNITAID. In addition, a number of member states make voluntary contributions and the Bill and Melinda Gates Foundation provides financial support. WHO, UNICEF and the Global Fund are implementing partners. UNITAID's secretariat is located at the WHO headquarters in Geneva and its governing structure is largely modelled on the Global Fund.

Although the airline levy is quite small and the number of participating countries is limited, UNITAID was able to purchase medicines with almost \$600 million from 2007–10. Through its strategic market intervention, UNITAID has been successful in decreasing the price of medicines for HIV/AIDS, tuberculosis and malaria by 50–70 per cent, depending on products and market niches. Thus, it has contributed to increasing the supply of drugs and diagnostics in developing countries.

* Source: Jönsson, C., 2013. 'The John Holmes memorial lecture: International organizations at the moving public–private borderline'. In: *Global Governance: A Review of Multilateralism and International Organizations*, 19(1), pp. 1–18; and adapted in *Commonwealth Governance and Growth* 2014.