

Public—Private Partnership in Countering NCD



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As both Margaret Chan, Director General of the World Health Organization, and Ban-Ki Moon, Secretary General of the United Nations, made clear at the High Level Meeting on NCDs (noncommunicable diseases) in 2011, countering the global pandemic of NCDs requires the whole of government and the whole of society [1,2]. The pandemic cannot be countered simply through health systems, but requires input from many national and local government departments (finance, trade, agriculture, education, and transport as well as health) and from nongovernmental organizations, academia, and the private sector. Cooperation with the private sector, although often controversial, is essential if we are to reduce suffering and premature mortality from NCDs.

Much of the controversy centers on private sector purveyors of the risk factors for NCD (tobacco, poor diet, physical inactivity, and the harmful use of alcohol) and their levels of engagement. The health world's position is that there is little to no room for cooperation with the tobacco industry.

Some draw parallels between “Big Tobacco” and “Big Food” [3], but an obvious difference is that we need food to live, whereas we do not need tobacco. Indeed, in a world with a billion undernourished people and a billion obese people, improving the quality of the food supply is essential. Cooperation with the food industry has led to a 20% decrease in salt consumption in Britain [4]. The role of governments is critical for the success of those alliances, and many governments already have voluntary programs with the food industry to either reduce salt levels in bread (e.g., Austria, Chile, Hungary, and Mexico) or have passed legislation (e.g., Argentina, Paraguay, and South Africa) to limit sodium in bread and flour [5]. Something similar might be achieved for sugar, and we are seeing governments like the ones in the United States and Mexico already imposing taxes on sugary drinks, including sodas. It seems that there are plenty of opportunities to engage with the food industry, because they can shift to healthier options, although when it comes to alcohol, the opportunities for cooperation seem to be more limited. Pharmaceutical companies clearly have a role in countering NCD, with one of the most pressing issues being better availability and access to well-established drugs like antihypertensives and statins. This means companies moving away at least in part from their traditional high price, high margin model. And overreliance on drugs may replace or obstruct nonpharmaceutical responses like losing weight, changing diet, and exercising more.

Private (or nonstate) health care providers must have a role in preventing and managing NCD in low- and middle-

income countries for the simple reason that they are the main providers [6]. Private health insurers are also likely to have a global role, because many countries aspiring to universal health coverage are wary of the government picking up the full cost of health care, as happens, for example, with the National Health Service in the UK.

We both worked with a public private partnership to counter NCD as we directed the 2 sides of a collaboration between the National Heart, Lung, and Blood Institute (NHLBI), the UnitedHealth Group, a health and well-being company organizing care for some 70 million Americans [7]. Through that partnership, we jointly helped develop 11 centers in low- and middle-income countries that would do research, build capacity, and advise on policy in relation to NCD. The 2 institutions were linked at the highest strategic level and worked together every day on operations, a formula that worked well.

The NHLBI wanted to make a contribution to global health through NCD research and training and UnitedHealth wanted to develop philanthropic programs outside the United States as its business grew internationally. The NHLBI, with its emphasis on discovery, and UnitedHealth, with long experience of delivery, complemented each other. The program began in 2007 when NCD was not high on the global agenda and when it was challenging to get funding for NCD research in low- and middle-income countries. Eleven centers were created (4 in Asia, 3 in Africa, and 4 in Latin America), and as articles in this issue of *Global Heart* show, much has been achieved. Funding from the NHLBI and UnitedHealth ended more than 1 year ago, but the centers are flourishing. The program also attracted other partners like the U.S. Centers for Disease Control and Prevention, Medtronic Foundation, and the American Thoracic Society, who contributed to the success of the centers.

To make an important contribution to countering the pandemic of NCD, innovations developed and tested in research programs need to be scaled up. Sadly, only a minority of effective innovations in any part of health are scaled up, and Bill Gates recently bemoaned how few if any of the innovations developed in his grand challenge programs have had much impact [8]. This failure may in part be caused by confusion over whose job it is to scale up innovations. Researchers are rewarded for doing research, not scaling up innovations, may not see it as their main area of responsibility, and may not have the necessary skills.

An example of successful—but long delayed—scale up is a program to prevent people progressing from prediabetes to diabetes. Trials completed in the 1990s showed that intensive one-on-one counseling on lifestyle change

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were effective in preventing the progression to prediabetes [9], but after more than a decade the U.S. Centers for Disease Control and Prevention and UnitedHealth combined in a public private partnership to develop a much cheaper program with group counseling and a viable business model [10]. This allowed tens of thousands to benefit from the innovation, and a subsequent development of a program built on a reality television program may allow even more to be reached [11].

One of the innovations developed in the NHLBI/United Health program improved primary care of patients with NCD (and other conditions) in rural South Africa where doctors are rarely available. The Practical Application of Care Kit comprises simple evidence- and policy-based guidelines; onsite, team-based training; system change, particularly nonphysician prescribing; and systems of scale up, monitoring, and evaluation [12]. It has been developed over 15 years by the Knowledge Translation of Unit of the University of Cape Town and is now used in 2000 clinics in South Africa. Potentially, it solves the problem of weak primary care services experienced in many countries. Other countries have now expressed an interest in adopting the Practical Application of Care Kit. The Knowledge Translation of Unit, a small academic organization, lacks the business skills and sales force needed for global expansion, but a public-private partnership with the BMJ is allowing this to happen.

The global program to reduce the burden of NCD is at its beginning in most low- and middle-income countries [13], and it may well be that a global public-private partnership along the lines of GAVI, the Vaccine Alliance, may be needed. GAVI was formed to ensure that vaccines would be available in countries that might not otherwise be able to afford them and for conditions that might not be viable for the private sector alone [14]. It brings together agencies from the United Nations, governments, the vaccine industry, private sector, and civil society. By 2015, GAVI had reached 500 million children that might otherwise not have been vaccinated and saved 7 million lives [14].

It might be that such a global private partnership could help, for example, with increasing the availability of the polypill, a single pill combining antihypertensives, a statin, and possibly aspirin that might prevent up to three-quarters of heart attacks and strokes [15]. At the moment, <4% of the people in low-income countries who have had heart attacks or strokes receive the drugs in the polypill [16]. Those drugs have long been known to reduce recurrent heart attacks and strokes, but business and regulatory problems are preventing the wide availability of the polypill at a low cost [15]. A global public-private partnership might be able to surmount these blocks, as GAVI has done for vaccines.

There will always be conflicts of interest between the public and private sector as, indeed, there will be among institutions within the public sector. It is essential to recognize and manage these conflicts, often through disclosure but sometimes by exclusion. It is important that conflicts are managed with transparency, accountability, and ethical conduct. Many successful public-private partnerships, including GAVI and the partnership between the NHLBI and UnitedHealth, have shown this is possible; and it is clear, as Chan and Ban Ki-Moon recognized, that all of government and all of society, including the private sector, is needed to counter the pandemic of NCDs.

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