MAKING PUBLIC-PRIVATE COOPERATION WORK FOR DEVELOPMENT

Lessons from private initiatives in health and development

Seminar report on the occasion of the awarding of the 2004 Helffer-Kootkar Prize to the World Gastroenterology Organisation (WGO/OMGE)

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Seminar report

1. Preface

The *Helffer-Kootkar Prijs Stichting* is a foundation that promotes social citizenship by periodically awarding a prize from the bequest of the Dutch entrepreneurial couple Helffer-Kootkar to individuals and institutions that contribute to the social participation of people in marginalized positions in the Netherlands and abroad.

The 2004 Helffer-Kootkar Prize was awarded to the World Gastroenterology Organisation (WGO/OMGE) for its efforts in developing countries to enhance early and effective diagnostics and treatment in gastroenterology and related diseases through training and education, including the use of medical technology for endoscopy. The WGO/OMGE has set up a programme to establish training centres around the world offering didactic components and practical instruction in advanced medical equipment. The first WGO/OMGE Training Centre was founded in Soweto, South Africa in 1999; the second was set up early 2003 in Rabat, Morocco, and others are under construction.

The decision to award the Helffer-Kootkar Prize to WGO/OMGE was also made to honour Professor Guido Tytgat, President of the World Gastroenterology Organisation. In the Netherlands, Professor Tytgat pioneered the introduction of high-tech diagnostics in gastroenterology. He also dedicated a large part of his private time to the work of WGO/OMGE.

The subject of the 2004 Helffer-Kootkar Prize – how to help fund the efforts of the WGO/OMGE to implement high-tech medical techniques in low and mid-income countries – prompted a number of interesting issues and questions. Discussions on the “pro’s and con’s” led the *Helffer-Kootkar Prijs Stichting* to use the awarding ceremony as the occasion to hold a seminar on the theme of public-private partnerships and development, including medical development.

The seminar was organized by the Royal Tropical Institute (KIT) on behalf of the *Helffer-Kootkar Prijs Stichting,* preceding the awarding ceremony which took place on 17 March, 2004 at KIT in Amsterdam. This document presents a report of the seminar.

Prof.dr. Lammert Leertouwer
Chairman, *Helffer-Kootkar Prijs Stichting*

2. Introduction

For many years, official development assistance (ODA) to low and middle income countries seemed incompatible with private sector initiatives. ODA had its roots in charity while the private sector was looking for profits. ODA interests were on the side of recipients; the private sector's interests were on the side of shareholders.

Aid recipients knew better and tried to make the best of both sides, but the lack of trust between ODA and private sector actors resulted in a lack of coherence. Eventually, a number of donors, including the Netherlands Ministry for Foreign Affairs (DGIS), understood the message and made public-private partnerships a top priority.

Precedents for cooperation between the public and private sectors in an ODA context did exist and provided the opportunity for the Netherlands Ministry for Foreign Affairs (DGIS) and the Ministry for Economic Affairs (EZ) to learn from these earlier experiences and identify bottlenecks and opportunities for fostering such partnerships.

The seminar *Making public-private cooperation work for development - Lessons from private initiatives in health & development* was held on 17 March 2004 at the Royal Tropical Institute in Amsterdam. The idea was to link those with experience to those involved in implementation.. The occasion was the awarding of the Helffer-Kootkar Prijs 2004 to the World Gastroenterology Organisation (WGO/OMGE).

The seminar's focus was on a key issue in development cooperation: how to share insights in medical knowledge and the technology needed for its application in "low tech" environments. The role of private initiatives and the private sector was also discussed. The seminar aimed to help identify bottlenecks and weaknesses in existing systems and decision-making processes, and to help recognize opportunities to transform good intentions into coherent and effective implementation policies. From this perspective, the seminar contributed to the current debate surrounding the role of public-private cooperation in development.

Participants included practitioners and other experts in health and development, policy makers, academics and opinion leaders in the field of medical development, representatives of non-governmental organizations and of the private sector, including the medical industry.

Based on presentations of concrete cases from various developing countries, the debate focused on issues such as:

- the conditions necessary for successful implementation of advanced medical knowledge, including required technologies, in low income countries (sustainability);
- the roles and responsibilities of foreign private initiatives, whether not-for profit or commercial, especially with regard to decision-making priorities in public policy;
- the pitfalls of, and opportunities for, public-private cooperation.

To prepare for the seminar, a position paper was distributed to foster discussion amongst those who were to deliver presentations during the seminar. This paper is included in section 3 of this document and tackles the following issues:

- What do we mean by partnership? – should coordination between the public and private sectors be based on a partnership?

- Should the private sector, if using public ODA money, be monitored using the same criteria as regular activities, such as poverty reduction, sector-wide approaches, strengthening national leadership, and the sustainability of interventions?
- What new opportunities are there for involving the private sector in ODA – and why would the private sector wish to be involved, anyway?
- For what should private initiatives be held accountable?

The seminar began with the opening remarks of the President of KIT, Mr. Jan Donner. He addressed the complexity of supporting a country, the need to meet the demands of different groups in society and for good governance: the need for a legal and regulatory framework to ensure the rights of all to health and health care.. Mr. Donner mentioned the role of the private sector in this and outlined some of the potential advantages of involving that sector.

Dr. Izy Segal of WGO/OMGE gave a presentation entitled ”Dysfunctional Health Care Systems in the Developing World: Is There a Solution?” Dr. Segal presented his experience with private initiatives within the context of ODA. The WHO/OMGE sent Western experts to share new high-tech knowledge with targeted hospitals in countries such as Morocco, South Africa, Egypt and Mongolia. In addition, national specialists were trained to use these technologies, through training of trainers and through technical support over the internet.

Ir. Paul de Leeuw of Philips Medical Systems gave a presentation on ‘’The Role and Interests of the Medical Industry: the Cases of Zambia and India”. In his presentation, Ir de Leeuw first explained that ODA countries may be less interesting to the medical industry because their purchasing power is low compared to Western countries. As a result, medical equipment is primarily available in the West, despite the demand for such equipment elsewhere. Ir. de Leeuw sees a role for manufacturers in helping to widen access to medical equipment and strengthen local capacity, as long as they are aligned with the donor community and have the support of public financing. Manufacturers may also be able to develop new products.

Jurrien Toonen (MD, MSc) of KIT touched upon operational policy issues in his speech ”Strengthening Local Import Capacity Public-Private Partnership.” Mr Toonen stressed that the issue is not only about stimulating export of medical equipment. Local structures also need to be supported to make interventions sustainable in all their dimensions, including, but not limited to, technical aspects like providing training and spare parts. Using examples from Gujarat, Ghana, Uganda, Turkey and Thailand, he presented a number of lessons learned, such as the need to complement the exportation of goods with that of services and the need to develop appropriate instruments for public-private partnerships. Development aspects make up only a tiny fraction of export subsidies and investments by private initiatives could have an enormous impact on national budgets for recurrent costs. A better coordination is needed between government ministries of finance and ministries for development cooperation/ODA .

The second half of the seminar programme was given over to discussion under the heading “Lessons for Policy and Practice: Comments from a Policy Perspective”. Mr. Rob de Vos, Deputy Director-General for International Cooperation, the Netherlands Ministry of Foreign Affairs (DGIS) and Mr. Iman Merison, Unit Manager, Investment and Export Finance, Foreign Trade and Investment Department, the Netherlands Ministry of Economic Affairs (EZ) reacted to the issues raised in the four presentations. In addition, the Dutch Minister for Development Cooperation,

Agnes van Ardenne, announced new government measures related to financing mechanisms for export stimulation in ODA:

- ORET, an older financing mechanism for export stimulation in ODA, will be re-introduced for Least Developed Countries, but will no longer be tied to purchasing to Dutch products;

- The awarding of ORET grants to stimulate export will be made partially dependent on development relevancy, attention to knowledge transfer and capacity building, and per capita income;

- There will be no difference anymore between the different countries eligible for ORET financing;

- The fund for infrastructure development in Least Developed Countries, until recently available only to the private sector, will become available to semi-government operating companies (such as in the health sector);

- Instruments for financing the transfer of know-how and technical assistance in the private sector (e.g. PSOM, IFOM) will be simplified;

- PSOM will become available to more countries, and the funding will be increased to € 50 million per year.

The meeting concluded with the awarding of the Helffer-Kootkar Prize 2004.

Since the 2004 seminar, many more efforts have been made to foster public-private partnerships. More seminars have brought together business people and people from the field of ODA. Initiatives have been created for joint projects and each side has gradually begun seeking the other to undertake projects. Some of the blockades in Dutch policies have been lifted: nowadays, for example “export of services” is also possible. The Dutch Ministry of Foreign Affairs is actively seeking to foster public-private partnerships. But many of the issues raised during this seminar remain relevant, and not only for the medical sector in ODA.

3. Position paper

PUBLIC AND PRIVATE: PARTNERS IN DEVELOPMENT?
OPERATIONAL EXPERIENCES FROM THE HEALTH SECTOR

Dr. Jurrien Toonen, KIT Development Policy & Practice

CONTEXT

The decision to award the 2004 Helffer-Kootkar Award to the WGO/OMGE for their efforts to implement high-tech medical techniques in low and mid-income countries, prompted a discussion in the board of the *Helffer-Kootkar Prijs Stichting* on a number of interesting issues and questions and led the Foundation to use the awarding ceremony to hold a seminar on the theme of public-private partnership and medical development.

The discussions started with the question of whether it is appropriate to stimulate the development of high-tech technology in low income countries. Is this a priority for these countries? Who decides if this is a priority, and based on which criteria? Will this type of support be sustainable? Who will benefit? What will be the context – will it be an isolated initiative or will it be part of an integrated programme?

These questions are not easy to answer. Nobody would deny the right of the populations in the South to have access to this kind of health service. The activities of the WGO/OMGE appeal to one of the most important aspects of Dutch ODA, sustainability, and to one of the most important new developments in Dutch ODA policy: strengthening the relationship with private initiatives.

The WGO/OMGE initiative is one of many private Dutch ODA development initiatives to support low and mid-income countries. In the DGIS policy paper *Aan elkaar verplicht* ("morally obliged to one another") it is stipulated that there is a need for concentration and complementarity through partnerships to come to a coherent Dutch ODA structure. This means partnerships between the public sector (the Ministry of Foreign Affairs and the Ministry for Economic Affairs) and private initiatives in The Netherlands, to support a public-private mix in the South with goods and services.

Although the intentions behind the Dutch policy to work with the private sector in ODA activities are clear, for many the implementation of this policy is much less so. The existing experiences with Dutch private ODA initiatives, such as the medical equipment sector and technical assistance, will be used as an example during this seminar to identify the pitfalls and weaknesses of the existing systems and to identify opportunities for strengthening the implementation of this policy.

This paper outlines some important development issues that are presently being discussed in the Netherlands and provides the background for the three presentations that follow on operational aspects of public-private partnerships. This paper will set the scene first by describing what a partnership would entail and what kind of partnership is implied in this context. The intention of DGIS to develop "partnerships" implies a change in its relationship with private initiatives, going beyond a mere contractual relationship. In addition, the paper will address issues that are essential to DGIS' relationship with other partners, such as SWAp and poverty reduction.

In the discussion section of this paper, a number of questions will be addressed that are of key importance in developing a relationship between the public and private sectors. For example, the

opportunities to involve private initiatives in the health sector in low and mid-income countries will be explored, using examples that show the comparative advantage of such an involvement. The question of why the private sector should be at all interested in getting involved in ODA, when the market in low and mid-income countries is limited, will also be addressed. Regarding accountability, DGIS and EZ are increasingly interested in seeing the results of their spending of taxpayers' money. When investing public funds in public-private partnerships, how should these partnerships be held accountable? Should results be measured according to increased exports (EZ) or according to some kind of "development" criteria (DGIS)?

SETTING THE SCENE: SOME KEY ISSUES

Types of public-private partnerships

Firstly, what type of public-private partnerships (PPP) are we talking about? In the context of this seminar, we are focussing on partnerships in the North that originate from initiatives in the private sector, be it for-profit (like Philips Medical Systems) or not-for-profit (like the OMGE itself). These initiatives are not generally initiated by the public sector but require logistic, financial or diplomatic support from the public sector. In this context (the example of the medical sector), the natural partners are DGIS, the Dutch Ministry of Health (VWS), EZ, their implementing agencies (Senter, FMO) or their representatives at embassy level. These initiatives may serve clients in the South: public, private or a public-private mix. (Note that the public-private mix in the South will not be focused on here.)

Gill Walt has distinguished the following types of PPP:

1. Product-based partnerships, to enable the distribution of a specific product; often requiring a high degree of "market creation" and company PR, these need careful appraisal to ensure development relevance and cost effectiveness. The case study of PMS for the conference represents an example of this type of PPP.
2. Product development-based partnerships, e.g. the collaboration with a company to develop a needed diagnostic tool. These are more likely to arise out of a need to complement research and field knowledge with production knowledge and capacity. These need careful appraisal in terms of the ownership of intellectual property and sustainability.
3. Issues/systems-based partnerships, in which private and public actors collaborate around a series of objectives. These are likely to involve a much wider range of actors in a looser partnership. The KIT case study for the conference is an example for this type of PPP.

The third case study – on the OMGE experience – doesn't really fit into Walt's framework. This is not surprising, since this type of private initiative often takes place outside the scope of the institutionalized partnerships.

What is a Partnership?

Secondly, we easily cluster a number of activities and organizational forms under the heading of (Public Private) Partnership – but it is worth "unpicking" the cluster and thinking about definitions:

What are Partnerships and what makes them work?

Partnership definition[1]
Inter-organizational relationships involving activities beyond that which contracts or authority alone would warrant, aimed at achieving shared goals based upon close working relationships.

Partnership is a general term used widely to describe a range of inter-organizational relationships and collaborations. As a result, there are many different definitions of what constitutes a 'partnership'. In a review of the literature, Watkins and Csaky (2003: 13) find that two common themes emerge: i) A sense of mutuality and equality between those involved, including the attitudes of the partners working together and a sense of trust between those involved; and ii) mutual commitment to agreed objectives, reciprocal obligations and accountability, whether these are laid down in a formal contract or are more informally agreed on. These two qualities can be expressed as unity and direction – the unity between individuals and organizations, and the direction (or overarching goals) of the partnership shared among its members.

As a form for organizations to work together, partnerships may be distinguished from both market-based relationships determined by contract, and from relationships in the public sector involving hierarchies based on authority. Partnership working is distinct from both of these in that, like inter-organizational networks, it involves collaboration and co-ordination between organizations based upon trust (Thompson et al 1991). Trust is the control mechanism in networks and partnerships (Powell 1991); without trust between actors, there is little to distinguish a partnership from a contractual or authority-based relationship.

Four sets of concepts appear to be key to effective partnership working and these we plan to probe: trust, values, communication and network attributes. Trust embodies reliance, dependence and the acceptance of risk. Having shared values embodies joint commitment to common goals. Clear and understandable communication is often a prerequisite for the development of trust. Network attributes refers to the degree of centralisation or openness in the partnership, its stability in terms of its resources, its agenda and the actors involved, and the ability of the partnership to facilitate the acquisition and transfer of resources and to add to the capacity of partner organizations.

This prompts a number of questions on a public-partnership with private initiatives, such as:

Is there unity between the partners? Do they share direction and values? Is there mutual trust? How well are the communication and network attributes organised for the partnership working?

If the answers are 'no', there seems to be no ground for speaking of a partnership. This is in no way a matter of semantics – the consequence would be a contractual relationship (probably the public sector contracting the private sector), including authority lines, monitoring of accountability and compliance with the contractor's criteria, mission and vision.

What criteria to apply?

[1] From a recent DFID WHO evaluation KIT has performed.

Thirdly, in the Netherlands, DGIS is a (the?) main player in the public sector. In its view, ODA should originate from international solidarity and shared responsibility. From the policy paper "Aan elkaar verplicht" we can learn the criteria for ODA as used by DGIS – such as:

- support should be provided in partnership: based on policy dialogue, also for reasons of pressure and influencing policy,
- focus on results and effectiveness of the support provided,
- the support should show a clear probability that it will reduce poverty,
- support should contribute to stability and security in conflict areas,
- there should be a clear case of good governance – for example the civil society should be involved in determining the programme's priorities,
- support should be sustainable, the commitment should be long-term.
- and as over-arching themes: there is a need for coherence (coordination with other donors) and complementarity (with the different "partners" involved in ODA)

DGIS and other ODA organizations currently find it important that the approach be "sector-wide" (SWAp: Sector-Wide Approaches). Again it would be useful to define this concept here (Cassels):

> At the heart of SWAp is a national comprehensive medium-term collaborative programme of work concerning:
> - The development of sectoral policies and strategies;
> - Projections of resource availability and expenditure plans;
> - The establishment of joint management systems by governments and donors to facilitate the phased introduction of common management arrangements;
> - The establishment of structures and processes for negotiating strategic management

In other words, all significant support should serve a single sector policy and expenditure programme (Foster). Consequently, partners are turning away from the project approach, as this is leading to "islands of excellence", which may result in a lack of coherence in national health programmes. Central to the sectoral approach is the need for a national leadership to define the sector programme, in such a way that this leads to a "sense of ownership", which would then strengthen the sustainability of the interventions. This is changing the relationship in donor coordination. Ideally, donors will stop selecting projects, will arrive at common approaches across the sector, will rely on Government procedures, and will support them in developing policies, strategies and tools. A step further is budget support: channelling funding through the Ministry of Finances, the donor's involvement will decrease further, leaving the recipient country with more autonomy in spending these funds.

What are the links with the Millennium Development Goals?

Finally, at the Millennium Summit in September 2000, United Nations members reaffirmed their commitment to working towards a world in which sustainable development and eliminating poverty have the highest priority. The Millennium Development Goals (MDGs) were adopted and generally accepted as a framework for measuring development progress. These provide yardsticks for measuring results, not just for developing countries but also for rich countries that help to fund development programmes. Both donor countries and low and middle income countries will be held accountable for attaining the MDGs by 2015. There is no programme or process in place to achieve these MDGs; the most important instrument is the PRSP (poverty reduction strategy plan) which has been developed in nearly all of low income countries.

This conference is not the appropriate platform to discuss the efficacy of concepts like SWAp, MDG, PRSP, etc. Leaving this discussion to other forums, the questions for this conference will be:

> Should ODA-initiatives undertaken by private initiatives be responsive to ODA criteria – or only if they receive DGIS-funding? And should private initiatives be coherent with DGIS approaches (like SWAp or Budget Support instead of project approach, to enhance local ownership and priority setting – and coherent with the global initiatives related to poverty reduction to which the Netherlands has committed itself, such as MDG, PRSP and HPIC)?
>
> Do private initiatives actually have a relevant role to play in the development of recipient countries (for example by strengthening local import capacities), or is the real objective to stimulate the export of Dutch products? And if so – does export only concern capital goods or also services (like technical assistance)?

Discussion

It goes without saying that the conditions in low and mid-income countries are different from those in the Western world. There are too many market failures to mention for these countries to leave private initiatives open to free market mechanisms. There is a need for almost everything, but resources are limited, as are the possibilities to make informed choices. This does not mean that there is no place for private initiatives, like many in the ODA world have argues, but there are some rules of the game[2] that these initiatives should adhere to, which still need to be elaborated. It would be a waste of resources if these private initiatives did not form part of one coherent integrated approach in ODA. There are too many opportunities.

What opportunities are there to involve private initiatives in the ODA-health sector?

DGIS, in its policy paper “aan elkaar verplicht”, states that, to arrive at a coherent policy, complementarity with these private initiatives is key. These initiatives can provide not only additional funds, but also specific expertise currently lacking in ODA. There are a few good examples to cite, such as TPG’s support for the World Food Programme in the management and planning of its logistics; the Dutch Task Force for Health Care’s provision of five extra years of maintenance when supplying medical equipment; Heineken’s dedication to AIDS prevention among its overseas labour-force; and Nuon’s assistance to African countries in setting up solar energy systems. Investing in these countries may, as a side effect, result in spare-part production and distribution centres being set up.

And of course there is **WGO/OMGE**, the inspiration for this seminar, which provides technical support to these countries. There is no doubt that there is an enormous gap in knowledge and expertise in technologically advanced medical diagnostics between the Western world and low and mid-income countries - and that there is an important demand for this type of technology. Providing the advanced equipment without the required technical capacities means a destruction of capital. Support offered by organizations like OMGE may help ensure the (technical dimension of)

[2] *rules of the game* which do not necessarily respond to conditions that exist in writing – but those which make a partnership more than a contract

sustainability. Certainly if, as in the case of OMGE, an investment is made in structures, rather than providing a one-off type of support: local trainers (not just isolated technicians) are trained, guidelines are developed, sessions are organised for local trainers to train national medical specialist and paramedics, and conferences and on-line follow-up support are provided. This methodology of offering support helps create conditions of technical sustainability. In this way the "import capacities" of the recipient countries can be strengthened.

There are opportunities for **broadening the scope** in the ODA-sector. It seems that many of the Dutch ODA-experts don't know what happens on the "market" – an important share of medical sector funding is spent on capital costs, while ODA-experts tend to focus more on functional costs (like training and institutional development). Also, a "new" focus could be added to the existing types of ODA support: besides advanced medical technology, there is much interest in know-how pertaining to the organization of the health sector in The Netherlands, like accreditation of hospitals, monitoring of quality standards, health financing and health insurance.

This does not mean that exploring these opportunities in private initiatives will automatically lead to a development of low and mid-income countries that is sustainable and appropriate. There are more dimensions to **sustainability** than just the technical – for example the institutional, financial and socio-economic dimensions. There is a good reason why most donors actually demand a sector-wide approach. The support should be financially sustainable; in the national health budget of the recipient countries capital costs need to be balanced with recurrent costs in the joint expenditure framework. The investments will automatically lead to recurrent costs such as maintenance, salaries, training and supervision – and this may in turn lead to an increase in user's fees which would decrease socio-economic sustainability. Each new initiative should be assessed in this light. This applies, not just to investments in terms of capital costs, but also of advanced technology, since technical support immediately leads to investments in equipment, hence "creating a market".

In countries with scarce resources, priorities have to be set and choices have to be made, particularly in countries that do not even meet the World Bank minimum standard of $34 per capita expenditure for a minimal package of health services. Here serious questions have to be asked on cost-effectiveness before sending high-standard medical technology. The exporting country should remain co-responsible. The donor country should aim for coherence between its ODA-type activities (like DGIS: aiming at "relevance for development") and those of economic affairs (like EZ: aiming at "increasing export of capital goods"). This is certainly not impossible, yet not self-evident either. For example, CT-scans are sold, while X-ray equipment at district level could have resulted in the same profit, but with a higher effect on the health status of the population. Or, technical assistance is offered for the use of high-standard equipment, while basic equipment is not yet used due to a lack of know-how. Private initiatives tend to act "demand-driven" to meet criteria of developmental relevance – but the question is "whose demand?" Generally it boils down to the demands of high-ranking decision-makers.

This does not mean that this demand will be need-driven: needs, in terms of responding to priority problems in the health status, in terms of what the local professionals perceive as their needs, or what the health care consumers perceive as their needs. The identification of the needs is essential, and their translation into demand is of key importance for private initiatives to have an effect on the health status and on development. To achieve institutional sustainability requires not only knowledge of technical issues (like calculating the burden of disease), but also of the

institutional framework, community involvement, civic reforms etc,. And it requires knowledge of social conditions, local “enterprise culture”, differences between socio-economic classes, to achieve socio-economic sustainability.

The presence of these capacities in private initiatives is not obvious, nor should one expect them to develop them: development usually doesn’t feature in their mission statement. If the approach of The Netherlands is to gain coherence, private initiatives need to be accompanied by others who do have those skills and knowledge on evidence-based needs, resulting from studies on consumers- and professionally perceived needs. If activities are undertaken in partnership with knowledge institutes, “needs” may be translated into “demand”, the import capacities may be strengthened, structures can be put in place, and the different conditions in the South or East can be translated for the private initiatives. Some examples given in the case studies show that it is possible, for instance to come to sector-wide planning of medical equipment issues.

So there are opportunities for private initiatives to be involved in ODA interventions; if accompanied by knowledge institutes these initiatives can be “development-relevant”. But one might well wonder what the drive is for private initiatives to become involved in ODA.

Why would the private sector at all be interested in being involved?

For private initiatives like the OMGE, this is not difficult to explain. Solidarity is certainly a motivating factor in transferring knowledge from countries like The Netherlands where the expertise is widely available to those where it is not. This motivation also has an intellectual and technical dimension. As their salary is pre-given, direct financial interest is probably not part of their drive, and we may assume that experimentation (e.g. with new technologies for the for-profit industry) does not motivate their decisions. They usually devote their private time to these activities, so a free flight ticket and sustenance allowance is often enough to enlist their support. This also calls into question the feasibility of their support, since they are only available when free from duties at home.

But the case of for-profit companies in the health sector is different. ODA is generally not part of their mission statement, so why would they be at all interested? They need to show positive results to their shareholders, which normally comes down to increasing their profits.

Reasons to participate in ODA activities may be that it creates a long term client relationship. The company establishes strong relationships with high-ranking officials in the recipient countries, and they hope to develop new markets. However, LIC represent only a small potential market for these companies. A positive “social” image may interest them as part of their PR or even “perception management” in society. In this regard, corporate sustainability and social responsibility are gaining weight. And of course particular employees may be personally sympathetic to ODA, and willing to cooperate as long as this does not interfere with the company’s objectives.

Some companies do not necessarily seek to profit from their ODA activities, but there should be no risk of incurring a loss. It has been shown all too often that clients in low and mid-income countries tend to be unreliable in paying off their debts, while donor organizations are not always predictable in awarding subsidies. Hence there are many risks for private organizations that may put at stake the company’s assets. For that reason charity foundations are set up (like the Gates Foundation) and if not, the risk for the company will be minimised. This means that the projects will be small,

risky projects are avoided or only accepted if Dutch governmental bodies (be it DGIS or EZ): guarantee for losses or subsidise the project. If not, there will be no long-term commitment from their side.

What should private initiatives in the health sector be held accountable for?

In case of not-for-profit private initiatives like the OMGE, accountability is limited. They organise their own fundraising, and they propose a number of activities to their foundation which are carried out. But the foundation will not check the effects or impact of their activities; letters of thanks from the beneficiaries serve to prove that the promised activities were indeed carried out. This of course reduces the transaction costs. Trust is the basis of the partnership between the foundation, those who carry out the activities and the beneficiaries. Whether the activities contribute to an improvement of the population's health status will follow from projections to effects and attribution. This, however, will be difficult to assess as the interventions are isolated projects within the context of the national health sector. Integrating these interventions in a PPP would increase coherence and accountability to compensate for additional funding by the public sector. Even more, perhaps the interventions then could become part of an overall plan representing the national priorities for support in the hospital sector.

In the case of for-profit private initiatives, the picture is somewhat different. There are no ODA-related issues in the mission-statement of most private enterprises, so they are held accountable by their shareholders on other issues. In case it receives support from the Dutch public sector, accountability may be based on the source of funding: it will be on export stimulation if funding is provided by EZ, on local import strengthening and ODA criteria if funding comes from DGIS. But for reasons of coherence, the source of funding should not make a difference – abroad it will hardly be understood that there is a difference between different types of Dutch funding. The Netherlands has committed itself at global level to a number of engagements on ODA (PRSP, SWAp, MDG). So, monitoring and evaluating the effectiveness of public moneys will then probably include ODA criteria.

Which criteria will be **monitored** depends on the form of coordination between the private and public sectors. If public ODA money is provided to private initiatives, contracting-out is of course most straightforward, and such a contract will establish what the private initiative will be held accountable for. But what type of criteria will figure in these contracts? Effectiveness will probably be monitored by the deliverables that were promised, but will poverty-reduction and contribution to the MDG be part of the indicators monitored? Then there is the degree of coherence with the national health plan (including its expenditure framework), and the degree to which the interventions meet the health needs – or only the demand? Will criteria like sustainability be limited to "technical sustainability" (training local experts or a 5-year contract on spare-parts and maintenance), or also address the institutional, social-cultural, and financial dimensions of sustainability?

Since the Millennium Summit in Monterrey, one major and overriding criterion for DGIS and other donors is **poverty reduction**. The Netherlands and the other UN-member states have committed themselves to reducing poverty by half, and health is a major issue here. Thus this is not only a DGIS issue, but also for EZ. Then the question is: will private initiatives also be held accountable for the effect of their interventions on poverty – and what would that mean? Should their interventions aim at poor areas, should they develop products (like medical equipment) or services

that serve the poor, or should they ensure that their interventions do not exclude the poor? No programme has been established to attain the MDG that were agreed upon during the Monterrey summit, and so far the PRSP is the only instrument available for working towards the MDG. For-profit companies cannot participate in established Dutch poverty programmes – but will they be accountable upon participation in PRSP?

The Dutch Government is called upon to provide more precise criteria. Some issues may already be clear. The risk that "charity-like" activities become mixed up with commercial objectives should be minimised. To avoid having scandals (like ENRON, Ahold, etc.) embarrass ODA-activities, but also because the trading environment is different in low and mid-income countries (corruption, limitations in legalisation and a lack of information), a code of conduct is required. There should be no effects of fungibility, whereby additional private funds are taken as an excuse for a partial withdrawal of public sector (DGIS) funding for ODA activities.

And of course there's the question what consequences the monitoring and evaluation results will have: what will happen if the companies do not deliver what they had promised? What will happen to the Dutch-ODA activities if local partners do not meet their expectations – will other types of ODA support then come under pressure?

Are the existing instruments appropriate for developing a public-private partnership?

The intention to work with the private sector is clearly expressed in DGIS policy paper, after years of discussions on the appropriateness of such a policy – this will not be the central topic of discussion at this conference. The point is that the expression of this intention has not yet been followed up by an operational policy. In bringing the relationship between the private and the public sector into practice it seems that the instruments in the public sector are often not conducive to coordination and partnership between these sectors. Good practices and constraints in implementing a public-private partnership will derive from case studies presented during this seminar.

Conclusion

Coordination between private initiatives and the public sector in ODA is not something completely new – instances of it have been around for a long time. What is new is the fact that the Dutch Ministry for ODA has expressed its interest in a partnership with private initiatives. Indeed there are opportunities for an added value by complementing the existing ODA activities with private initiatives. The approach will become more coherent if a working relationship can be established. For this kind of working relationships, a clear distinction should be made between private initiatives carried out by not-for-profit organizations like the OMGE and by for-profit enterprises.

There are many not-for-profit private initiatives, based on charity and solidarity. The bright side of these is the fact that they are able to respond directly to a demand in a LIC or MIC, and they can operate without the weight of bureaucracy with low transaction costs. However, they may easily lead to small "islands of excellence". A partnership with the public sector could mean (financial, logistical or other) support in exchange for a frank discussion on the coherence of the interventions in the context of the recipient country's sector plan, and on the different dimensions of their sustainability. This may lead to a memorandum of understanding and eventually to a partnership.

A contractual relationship with the for-profit sector seems to be more appropriate at the start of the "new" relationship with the public sector. In these contracts one would expect agreed-upon objectives, reciprocal obligations and accountability. Once one can speak of unity and direction, through cultivating "trust", improved communication and strengthened network attributes, the working relationship may grow to become a partnership. Unity and direction will probably be linked to basic ODA-principles if the funds derive from the DGIS budget – such as adhering to the country's sector programme and PRSP, donor coordination and a calculated effect on poverty. In exchange the public sector would be committed to minimising the company's risks and to playing a proactive role.

In this, the approaches of EZ and DGIS should become more coherent. As yet one cannot speak of unity and direction between these representatives of the Dutch Government. Export stimulation to low and mid-income countries should not only be demand-driven, but also needs-driven. It should be responsive to the international agreements to which The Netherlands has committed itself. Hereto the import capacities of the recipient countries should be strengthened to ensure that they can make informed choices and that the necessary structures are capable of receiving the imported goods. These goods will have to be accompanied by an "export of services" to ensure that the necessary knowledge for the goods will be available. Also in regard to export we are "verplicht aan elkaar" – the motto of DGIS policy paper – "morally obliged to one another".

There are many good intentions behind the aim to develop public-private coordination (not partnership), but the rules of the game are not yet well established, and the instruments lack practical handles. This conference should establish the bottlenecks and provide suggestions for the way forward.

4. Seminar presentations

4.1 Dysfunctional health care systems in the developing world: is there a solution?
Dr. Isidor Segal, World Gastroenterology Organisation (WGO/OMGE)

4.2 The role and interests of the medical industry: the cases of Zambia and India
Ir. Paul de Leeuw, Philips Medical Systems

4.3 Strengthening local import capacity public-private partnership: operational policy issues
Dr. Jurrien Toonen, KIT Development Policy & Practice

DYSFUNCTIONAL HEALTH CARE SYSTEMS IN THE DEVELOPING WORLD: IS THERE A SOLUTION?

Dr. Isidor Segal, WGO/OMGE

SYNOPSIS

Upheavals in Africa culminated in the breakdown of health services during the latter part of the 20th century. With the end of colonisation and the death of apartheid, an opportunity arose for the rehabilitation and regeneration of health services. An idea for the creation of an institute of digestive diseases in South Africa was tendered.

At this important juncture OMGE, led by Meinhard Classen and later taken up by Guido Tytgat, facilitated the genesis of a digestive diseases institute in Soweto as a stepping stone to advance gastroenterology in developing countries. They shepherded the development of other training institutes and expanded the concept to foster education into a global strategy, with a philosophy that has wide ramifications in changing the scope of medical progress in developing countries.
OMGE, a non-profit private initiative, has acknowledged the major problem of dysfunctional health-care systems in developing countries.

The success of OMGE's programmes will be measured in the future by sustainable partnerships between developed and developing countries which will fulfil the goals of the OMGE initiative. In order to maintain this standard, it is important that standard financial and logistical support is provided by the public sector.

1. INTRODUCTION

From the mid-1950s onwards, Africa provided fertile soil for medical advance, and medical schools such as those at Makerere and Nairobi won particularly high reputations for their work on geographic pathology. Sad to say, political strife and internecine wars have destroyed some of the paramount institutions and destabilized medical training. In South Africa, the political philosophy of apartheid isolated the leading economic power so as almost to preclude cross-fertilization of ideas with others on the continent. But then, in the early 1990s, came the end of colonialism and the demise of apartheid; new opportunities emerged for medical advance in Africa. Among gastroenterologists an ambitious plan was drawn up with the triple aim of ameliorating disease, improving standards of health and education, and inspiring confidence that Africa can contribute to the solutions of medical problems in the huge continent. The aim was to establish an African Institute of Digestive Diseases.

2. THE INSTITUTE

The background to the idea is that conditions such as diarrhoea, viral hepatitis, AIDS affecting the digestive system, and malnutrition are endemic or common in Africa; cancer of the oesophagus is a major killer in men; among urban dwellers the increasing incidence of alcoholism takes its toll on liver and pancreas; and certain epidemiological enigmas (eg high Helicobacter pylori prevalence, low stomach cancer incidence; low occurrence of colon cancer) demand research. As ARP Walker – perhaps the last of the great pioneer researchers – continues to emphasise, Africa is a golden soil for researchers. Alas, in the continent as a whole, the resources to investigate and treat are

generally poor. Even basic diagnostic instruments such as proctoscopes and sigmoidoscopes are often lacking to say nothing of fibreoptic endoscopes, ultra-sound machines, X-ray equipment, and buildings to house equipment and staff. Where equipment is available, there may be nobody with the skills to operate or maintain it. A shortage of skilled teachers means that clinicians must often teach themselves, and there is negligible contact between local clinicians and international experts. Post-graduate courses and conferences have scarcely got off the ground, and libraries cannot function effectively because of the high cost of books and journals.

If the case for an Institute was clear, where was the best place to site it? The decision was to locate it at Baragwanath Hospital, Soweto, Johannesburg – the largest hospital in the world (3200 beds) and a major teaching hospital of the University of the Witwatersrand.. South Africa is blessed with a well-developed infrastructure and an excellent tradition of clinical practice and research. Soweto, with a population of 3-4 million, is a coalescence of a divergent and rapidly changing society including immigrants who have been resident for 30, 40 or 50 years; migrants who return each year to their families in rural areas; and urban born and bred people who are second and third generation Sowetans. In this kaleidoscopic milieu lifestyles, and particularly dietary patterns, are in process of transformation. Sowetans are, in fact, a people in transition – sometimes rapid, sometimes gradual. The existing gastroenterology unit at Baragwanath was established in 1975 and has won an international reputation with over 200 scientific publications. A similar pattern of urbanisation is emerging throughout the African Continent.

3. ROLE OF WGO/OMGE IN FACILITATING THE ESTABLISHMENT OF THE INSTITUTE

This may be seen as a public-private partnership case study. When the plans for the Institute were being drawn up, it was clear that the road ahead was going to be rough. Professor Meinhard Classen entered the scene at this point. His vision was to assist developing countries in establishing training centres and he was supported in the initiation of this plan by the Munich Gastroenterology Foundation. They offered practical assistance and were able to obtain funds from many sources, leaning on members of the organization and business friends. Professor Meinhard propagated the Institute's ideals to OMGE. They 'adopted' the Institute and gave us not only start-up funding to establish the physical building of the Unit, but also strong moral support which was vital in the early and difficult days. In addition, Meinhard worked assiduously to provide us with state-of-the-art educational material and various types of equipment.

He created the embryo of the Institute and guided it through its infancy. The man responsible for stimulating growth from the embryo into adolescence and adulthood has been Guido Tytgat. There has been a long tradition of co-operation between S.A. and the Netherlands and in particular between the AMC and Baragwanath Hospital. This began with a visit by Guido in the early 1980s. These were the dark days of apartheid and Guido wanted to specifically see how black patients were being treated. He was overwhelmed by the enormous number and problems faced by critically ill patients in the hospital and the commitment of the staff to the healing of these patients, and he wholeheartedly supported us in our efforts. Humanitarian that he is, he realised that, despite the evils of apartheid, it would be wrong to punish Sowetans by adhering to what theoretically was academic isolation but practically meant punishing patients.

From this time until the present, there have been organised visits by health workers, Dutch doctors sent literature, and generally spread the word to influential friends to assist development of gastroenterology in developing countries.

Guido cut through local internal politics and this led to the expansion of the facilities and courses offered by the Institute. OMGE promoted this by conferring with SAGES to incorporate the Institute under its umbrella – and so the SAGES Academy of Digestive Diseases was born. This means that all the academic centres in South Africa are now open for the training of health-care workers which adds a further dimension to the original concept.

4. THE PROCESS OF PUBLIC-PRIVATE PARTNERSHIP

The original concept of the Institute was to break down barriers of ethnicity, language barriers and political boundaries. What we are witnessing is a transformation in medicine from a regional to a global philosophy spearheaded by OMGE.
The synergy of forces has mushroomed, impacting globally on digestive disease. This has enfolded into three arenas:

1. Establishment of training centres
2. Train the Trainers programmes, and
3. Education, using E-education and E-learning.

4.1 OMGE TRAINING CENTRES

1. Soweto, South Africa
In total, 15 health workers have received training for periods ranging from 2 months to 2 years. They are from various countries in Africa – Uganda, Zambia, Kenya, Cote d'Ivoire, Sudan and Mali, and consist of 7 doctors and 7 nursing sisters and 1 medical technologist. The trainees have been very enthusiastic. There has been no culture shock and adaptation to local conditions has been rapid. Even language difficulties have been overcome with understanding and encouragement. They are exposed to all aspects of health profiles in urban and informal ('squatter') communities.Fortunately, programmes can be carried out on a lean budget, with funding of non-S.A. Fellows being only $1200-1500/year.

Health workers who have participated in the courses offered by the institute

i) Technologists
UGANDA: Mr Christopher Kibuuka, Makerere University
Training – maintenance of endoscopic and other essential hospital equipment

ii) Nurses
KENYA: Ms Grace Atega; Ms Beatrice Olukaka; MrSamuelNyambuti
UGANDA: MsMagoba
ZAMBIA: MsMwanamamakanda
SUDAN: Ms El Deen Mohamed; A Alla

Training focused on:

- primary care guidelines in AIDS, diarrhoea and hepatitis
- logistics of a mobile endoscopy unit
- duties of an endoscopy nurse.

iii) Doctors: COTE D'IVOIRE: Dr Max Lagaud

MALI:	DrA Kalle;DrM Fodjo
KENYA:	Dr K Mugambi (surgeon),
	Dr H Lodenyo (Kenya Medical Research Unit),
	Dr S Kairu (Kenya Defence Force)
SUDAN:	Dr El Sayeed Baha

The health workers actively participate in interactive seminars, lectures, courses and conferences. Computer training is an essential facet of the training. An important aspect of the training is basic methodology in research.

In view of the expense of endoscopy equipment, emphasis is placed on care and maintenance of equipment and the trainees spend time at Olympus, Pentax and Fujinon maintenance centres. The doctors have been given the opportunity of attending an presenting abstracts at the SAGES meetings. In addition, Dr El Sayeed and Dr Lodenyo have published articles in international magazines.

The focus is on developing leadership skills so that the trainees will play an important role in training health workers in their home countries. The prototype created in Soweto has now been adapted to establish other institutes in Cairo, Bangkok, Karachi and Morocco.

2. Cairo, Egypt

The Cairo Training Centre (CTC) was launched in March 2004, under the patronage of the Prime Minister of Egypt and under the direction of Professor Hussein Abdel-Hamid, to serve the Middle East and English-speaking countries of North and East Africa. The first course was launched in tandem with a multidisciplinary gastroenterology conference in Cairo, attended by over 750 professionals from the region. 26 trainees from 15 separate nations in Africa and the Middle East were nominated by their national gastroenterological societies to participate in the training programme which combined didactic sessions and hands-on training at the Theodor Bilharz Institute in Cairo. Portal hypertension, a major source of morbidity and mortality in the region, related to schistosomiasis and the various forms of chronic hepatitis was the particular focus of this first course. Further courses are planned for the next several years; the aim of the centre being to augment the training of young gastroenterologists in the region and to provide them with skills relevant to their patient population

3. Rabat, Morocco

Founded from an agreement between OMGE and Morocco Ministry of High Education – dedicated to provide theoretical and practical continuous training in hepatology - gastroenterology to French-speaking gastroenterologists in general and those from Africa in particular.

Facilities:

i. Lecture theatre with facilities for simultaneous translation – important because of polyglot languages of participants
ii. 3 rooms – workshops and training in computerised simulator allows virtual acquisition of most recent techniques in endoscopy and echoendoscopy
iii. Library
iv. Home comforts
v. State of art training Long term training (1 year): short term (8 days) 50 attendees Interactive education, workshops, clinical presentations, computerised training on simulators

Centre requires additional equipment including software and financial support, particularly for trainees

4. La Paz, Bolivia

The Bolivian-Japanese Institute of Gastroenterology centrehas recently been acknowledged by the World Gastroenterology Organisation as an OMGE Training Centre. It presents an interesting example of cross-cultural collaboration. The institute was built in La Paz in 1979 by the Government of Japan through a cooperation programme that also included training of Bolivian physicians in Japan and the presence of Japanese experts in Bolivia. The institute provides training in diagnostics and therapeutic endoscopy and other complementary diagnostic procedures for South American gastroenterologists from Argentina, Brazil, Colombia, Ecuador, Peru, Paraguay and Uruguay.

5. Karachi, Pakistan

The OMGE training centre at the Aga Khan University Hospital in Karachi has provided OMGE with an excellent opportunity to explore the benefits of telemedicine teaching. Two courses were held where transmission from Munich, Germany to Karachi allowed for live exchange on relevant topics between the two centres. This inexpensive and effective method of exchanging knowledge presents endless opportunities for private and public cooperation. Siemens Medical supported the Karachi project with funds and technical know-how. The next course is planned for June this year when the main Aga Khan University will be connected with a European centre and will also transmit to several other centres around Pakistan to which it is connected.

6. Bangkok, Thailand

Together with the Gastroenterology Society of Thailand, OMGE is currently planning the inauguration of a training centre in Bangkok. The first course is scheduled to take place early in 2005 for trainees from Thailand and the surrounding areas such as Laos, Myanmar, Cambodia, Vietnam, Sri Lanka, Indonesia, Malaysia, Brunei, Singapore etc.

7. Santiago, Chile

The Latin-American Gastrointestinal Endoscopy Training Centre was created in Santiago, Chile in 1997. Since then, 54 national and 101 physicians from 17 different countries as well as 13 endoscopy assistants have been trained at this centre. This centre has been designated an OMGE Ccentre of Advanced Training and OMGE is supporting the programme.

TRAIN THE TRAINERS

- Three meetings have already been held in Crete and New Zealand
- The focus is directed towards teaching
- Workshop consists of several modules. These include: teaching procedural skills, including endoscopy; evidence-based medicine: publishing and presentations
- Workshops are unique in that they bring together people from a variety of countries, cultures, languages and levels of seniority
- Educational issues dominate the workshop
- The emphasis is on trainers
- The message is that the role of trainers is to equip students with tools for undertaking their own learning process. It is envisaged that we should act as mentors, guides and counsellors.

E-LEARNING AND E-EDUCATION

- Internet has developed into the most powerful knowledge base known to mankind and is the obvious choice to allow widespread dissemination of information. Internet penetration is growing fast even in emerging economies. Accessible around the world and around the clock.
- For OMGE, E-Learning has distinct advantages – in particular the ability to reach an audience in all parts of the world including the developing countries where doctors cannot afford attending mainstream meetings.
- Most programmes are free
- It is now possible to obtain E-learning in endoscopy
- Important in maintaining Standards in Gastroenterology and developing Outreach Programmes.

CONCLUSION

Dysfunctional health care systems operate in a milieu that calls for desperate answers. In the past 10 years, the huge gap in economies and health between the poor and rich countries of the world has widened. 150 million children in low and middle economies suffer from malnutrition. There is an inability to control the major killers. About 70% of the 40 million affected with aids people is found in countries with dysfunctional health systems. Tuberculosis has re-emerged with 9 million new cases and 2 million deaths each year. Similar death rates are occurring from malaria.

A major reason for the above situation is a lack of awareness and support from developed countries. This is underlined by the fact that less than 10% of the world's spending on medical research has been devoted to diseases that account for 90% of the world's disease burden. The current thinking about how to direct the skills and resources of richer countries to help the developing world revolves around government aid, tax incentives to encourage the pharmaceutical industry to assist, mobilisation of non-government organizations, and sourcing philanthropic bodies. However, issues that need to be addressed relate to the efficiency, bureaucracy and sustainability of sources of funding.

OMGE, as a non-profit private initiative, has been insightful in acknowledging these problems. An integrated process has been adopted to deal more comprehensively with partnerships between developed and developing countries. Bureaucracy has been streamlined and an emphasis has been placed on sustainability. Assessment of the various OMGE programmes have shown that they have the potential to extend influence from a local to a regional and to a continental level. In order to maintain this standard, it is imperative that financial and logistical support by the public sector is forthcoming.

OMGE has demonstrated that with vision and leadership, the goal is achievable.

THE ROLE AND INTERESTS OF THE MEDICAL INDUSTRY: THE CASES OF ZAMBIA & INDIA

Ir. Paul de Leeuw of Philips Medical Systems

There are huge regional differences in access to medical care. Eighty five percent of medical expenditure is consumed by fifteen percent of the world population. Spending per capita ranges from USD 3000 for the richest to USD 15 for the poorest.

Even in the poorest countries, medical technology is highly effective and indispensable for modern health care. The real challenge is to make the right (political) choices and strive for the highest impact within given socio-economic and institutional constraints, and subsequently make effective use of the chosen investments.

In all western societies, where resources are abundant, health care providers are highly professional and their organizational strength is at a level comparable to modern industry. Medical professional institutions are equally strong and well connected to the academic world. In such rich environments, health care providers seek continuous support and advice from the medical industry in order to guarantee that their medical services remain at the latest level and are being delivered in the most economic way.

Consequently, the business of a modern medical industry is only for 70% equipment and the remainder is a wide range of services that are demanded to support an optimal return on investment for health care providers. The most important demand can be observed for:

1. Joint needs and technology assessment
2. Training and education to match the skills level of direct users with latest technology
3. Maintenance and enhancements prolonging the equipment lifecycle
4. impact of IT in support of the clinical process

In addition the industry maintains intense relations with selected clinical and academic institutions in order to drive innovation of medical technology.

One can observe that only the 20% richest on this planet really benefit from these natural and fruitful relationships.

For all medical companies it is hard to economically justify a sustained presence close to end users in the poorest countries. Income per capita in e.g. Zambia is a factor 100-200 lower than in the Netherlands. The purchasing power of a Dutch regional hospital serving 100.000 people would therefore be equal to the budget of a Minister of Health in a sub-Saharan country with 20 million inhabitants. In the latter case medical technology however would be spread over an area of France or Spain and when adding the many other limitations, one begin to imagine the very difficult management task the same Minister of Health is facing.

Experiences with the enhancement and management of basic health technology (integral cost per capita EUR 0.5 per year) in six sub-Saharan countries in over 600 district and rural hospitals serving 50-100 million people has proven to lead to significantly higher utilization rates of equipment.

Also the World Health Organization observed that, especially valid for sub-Saharan Africa and poor South East Asian countries, “the issue is not the lack of medical equipment, but the presence of equipment that is not useable or not used”.

Absorption capacity at the policy level, but more so on the implementation level, is the limiting factor for an effective utilization of available funding.

Most visible is sophisticated equipment remaining idle due to lack of skilled operating and technical staff or absence of patients that can afford the medical service, but there are much simpler reasons for disappointingly low utilization rates of -even very appropriate- technology. If these issues are addressed first, low-income countries can get a much higher return on their investments in health technology. In terms of modern management these issues are not even very difficult or complex, but hard to tackle in a public sector environment where retaining people with sufficient professional skills is a continuous struggle. There are numerous examples of the inability to foresee, specify and manage total needs:

- when the necessary adaptations to buildings, water and power supply are not funded or executed, equipment remains unpacked;
- when the costs of operational supplies are not budgeted and supply chains are corrupted, equipment will come to a standstill;
- when maintenance is not managed, the useful life of equipment will reduce from 10-12 years to the 3-4 years observed in many countries;

Policies of donors can create additional problems. International competitive bidding rules do overemphasize initial cost, neglect lifecycle considerations and further undermine sustained presence of medical companies. Equipment standardization can reduce efforts and costs required to keep operational and technical staff at the right level. And therefore procurement and donation practices that lead to fragmentation of already small technology bases must be avoided. Highly recommended economies of scale only become reality when donors are keen on policies and act coordinated.

The recent conference: “The Role of Your Business in Development” (a joint initiative of the Ministries of Development Cooperation & Economic Affairs, NCDO and the VNO-NCW (Confederation of Netherlands Industry and Employers) ended with a clear invitation to the business community to define its future role in the development of low and mid-income countries. Today we can make the question more specific: What can be the role of the (Dutch) medical industry in the development of health care systems serving the worlds 20% poorest?

In view of the topics outlined above, guiding principles emerge:

- the industry should align with (MoH & donor) coordination efforts (Sector Wide Approaches, jointly formulated Health Sector Policies or Reforms)
- the industry should (e.g. through bundling, BOT set ups, autonomous operating companies) seek a broader role and make active contributions to coherence and sustainability; partnering with institutions that have complementary knowledge, and have (import) capacity building as their core business is of great value in that respect
- the added value of industry (apart from innovative products) is organizational strength and implementation power, attributes most needed in developing countries; these can only be transferred effectively in comprehensive, long term cooperative agreements.

The real issues can only be addressed if causes of fragmentation are removed. Financing instruments should be measured against these guiding principles.

Another challenge is the feedback of requirements to the innovation centres of the medical industry. Due to the size of the markets, the inability to specify total needs and the tendency to copy western practices in spite of huge socio-economic differences, the industry has not the interest nor activated knowledge to adapt technology to real needs of developing countries. The intense cooperation –observed in the Western countries- between health care providers and industry with the purpose to jointly shape the health technology of the future is here completely absent.

The knowledge, accumulated through partnering and comprehensive long-term cooperative agreements are a pre-condition for the development of technology specifically adapted for use in developing countries and countries suffering from extreme inequalities. Do financing policies and instruments supporting such best practices provide sufficient economic basis for the development of “appropriate” technology or should these be supported by special purpose innovation funding?

STRENGTHENING LOCAL IMPORT CAPACITY PUBLIC-PRIVATE PARTNERSHIP - OPERATIONAL POLICY ISSUES.

Dr. Jurrien Toonen, KIT Development, Policy & Practice

1. INTRODUCTION

Despite world-wide gains in health indicators, there is still a huge need for improvement, in low and mid-income countries in particular. This is above all to improve the well-being of the population, but also because investment in health delivers a six-fold economic return (as indicated by the CMH report on macroeconomics and health), and also because of pressure to reach the health-related Millennium Development Goals. Nobody would deny that medical equipment, and the accompanying technology, plays a role in achieving an improved health status – although not everyone would agree on the degree to which improvements may be attributable to equipment.
There is demand for medical equipment in low and mid-income countries – often this represents a major issue for decision-makers in the health sector – and the equipment industry responds to this demand. The Dutch Government (EZ) supports this type of export by providing different financial instruments (for example PESP and ORET). Another branch of this government (DGIS) participates in allowing these subsidies. But where the interest of EZ lies in increasing exports, for DGIS this is development, sustainable, within the confines of the local development process, in line with local absorption capacity.

The Dutch Task Fore for Health Care (TFHC) was founded by the Dutch industry to offer medical equipment as part of a demand-driven sustainable package. DGIS & EZ advised the TFHC to invite KI to broaden their scope and to adapt their approach to developmental approaches and strategies: “the subsidies should not only lead to a transport of boxes”.

KIT (and MUNDO and TNO) accepted this invitation because it acknowledged that the approach in the health sector should be sector-wide, and not exclude capital costs, for example for equipment. The coordination of their supply of services with equipment would increase the coherence of the approach. But, above all: according to its experience the delivery of equipment was often demand-, rather than needs-based. Needs in terms of professionally defined needs (according to the burden of disease, DALYs – and to professional perception of quality care) and of consumer-defined needs. Issues like accessibility (geographical and financial) of care, sustainability (institutional, socio-economic) and health system development were, in most cases, hardly addressed.

And here there was a chance for the KI to help overcome these constraints. And the cooperation with the private sector seemed to extend beyond equipment alone – later on we learnt that there were also opportunities for other kinds of private products (see below).

So there were good reasons for collaboration between the commercial equipment industry and the non-for-profit knowledge institutes. The KI could bring an added value to the export of goods to low and mid-income countries. Their contribution could result in an increased relevance of those goods in terms of development, by strengthening the import capacity in low and mid-income countries. This was acknowledged and appreciated by the “hardware companies”, and also by DGIS who

requested this contribution. KI moreover participated in the development of strategies, of project proposals and of a Code of Conduct.

But in working together we came across some operational constraints, which are the subject of this presentation.

Operational issues

- A first issue is the difference in **mission and vision** between EZ and DGIS. Their objectives are different: for EZ this means export stimulation, for DGIS this is development relevance. Their appraisal of proposals is often different for that reason – it is important to achieve more coherence in the approach of these two departments of the same Dutch Government.

2. CASE STUDIES

In the following case studies only a few aspects will be highlighted, only those that could lead to operational issues linked to the involvement of knowledge institutes.

Gujarat (India)

For the MOH of Gujarat, a 100 Million guilder project was developed for the delivery of medical equipment that was jointly financed by Gujarat/ ORET. This was not a TFHC project, but the coordination between the different institutes meant the birth of the concept. It provided several lessons learnt for a future TFHC.

Mother and Child Health, Traumatology, Kidney Diseases and Ophthalmology were (on demand) identified as sub-sectors. But it were only high-ranking officials in the MOH who had defined this demand. The appropriateness from a professional point of view was for that reason not certain: the different levels of care had not been consulted in defining the demand. KIT calculated the **needs** (in terms of burden of disease, expressed in DALYs) after project activities had already started. It appeared that ophthalmology and kidney diseases contributed but little to the burden of disease – much less than MCH and traumatology. It was clear that “needs” had not been at the basis of “demand”. The health needs as perceived by the consumer were not taken into account at all, so it was difficult to appreciate whether the demand was appropriate in this perspective.

Another consequence of the fact that **knowledge institutes** only got involved in a later stage, could be read from the budget: not even 1% of the total budget was dedicated to “soft-ware”. The activities to be financed in this way addressed “only” the training (of trainers) of the personnel that would use the equipment once it arrived. Later on, when the ceiling of the budget could no longer be changed, “soft” activities like hospital hygiene were added to the project. Anyway, discussions on the organization of the training activities meant the start of the involvement of the knowledge institutes.

Besides “demand-driven”, the intention of the project was that interventions should be **sustainable** –for the equipment manufacturers this meant training on handling the equipment and a 5 years contract for maintenance. The knowledge institutes then sought to add institutional, socio-economic and financial aspects to the concept of sustainability. These issues were discussed and provided lessons learnt for the future TFHC.

Operational issues

- DGIS and EZ should ensure that knowledge institutes are involved from the very start, when the project is conceived;
- In “demand-driven” the question should always be asked: ”Whose demand is it?” – the institutional framework of the demand-side should be respected to ensure institutional sustainability.

Ghana

The Ghana case also does not derive from a Task Force experience, but it provided some important lessons. The country was one of the first to embark on a **Sector-Wide Approach** (SWAp). In the mid-nineties an agreement was reached between the MOH and the donors on a joint national health plan, as well as on an implementation plan (the five years Plan of Work), including an expenditure framework. All were developed under national leadership – priorities, objectives, expected results, strategies and activity plan were worked out by the MOH and negotiated with the donors. Care had been taken to balance the Capital Costs with the Recurrent Costs – this was one of the major issues in reaching the agreement between the different partners. After the Plan of Work was already operational, a **commercial loan** was agreed upon to finance the building of regional hospitals and to stock them with medical equipment etc. This loan was agreed upon with the Ministry of Economic Affairs, outside of the PoW context, which caused confusion (and irritation) between the SWAp partners. Also, because different donors (amongst others the Dutch) were approached to finance the functional costs of these hospitals, as these were not foreseen in the PoW budget.

Operational issues

- EZ should keep a close eye on the consequences for the recurrent costs in a LIC or MIC when awarding requests for export subsidy for hardware such as equipment – the responsible ministries in most recipient countries are not likely to evaluate these consequences;
- Lessons learnt from the past on ODA should be applied to private initiatives: these should not lead to projects of isolated “islands of excellence” – whenever a SWAp (or a budgetary support) is in place in a country, the initiatives should be coherent with this process.

With these (and other) lessons learnt, the Task Force decided to develop, as suggested by DGIS and EZ, two proposals: one for a Low Income Country (Uganda) and another for a Mid Income Country (Turkey).

Uganda

A proposal was prepared for Jinja district and one referral hospital in Kampala. KIT provided support to overcome the objections that made DGIS and EZ decide not to support the first proposal. In their reaction, both departments questioned the sustainability of the proposed interventions. The TFHC was willing to change the approach in response to these comments by proposing two phases. The first would strengthen the local absorption capacity: technical assistance to strengthen management and planning capacities, health system development and health financing. This would prepare local health structures before the arrival of the equipment in a second phase. This approach was well received by the different partners. However, some remarkable events occurred:

This approach finally convinced the ODA secretary in the **Embassy** to give up his resistance to the plan. However, although there were no methodological obstacles anymore, bilateral ODA funds could not be used in the first phase of the project, because the district was not part of the embassy's priority area. So, although the secretary for economic affairs supported the proposal, it could not be carried out for a lack of ODA support from the embassy.

The **Ministry of Health** in Uganda was keen to have this project on board, as it could pilot a new approach of allocating equipment in the country. For that reason it was eager to receive a complete package, including technical assistance. Even so – the Ministry of Finance was hesitant to approve the proposal: normally international technical assistance was provided free of charge by the donors. In case of an ORET-financing the Government of Uganda had to pay 55% of the total costs – including technical assistance.

A Kenyan, who was known for having good contacts in the ministries, approached the TFHC members, offering his assistance in procuring a positive response from the GoU. The TFHC members did not accept his offer, as the person requested a **financial incentive** for his services.
It was surprising to see that it was not possible to award the Ugandan demand for support for the essential drugs programme due to ORET regulations. These regulations do not permit the inclusion of **drugs** in the programme, even though it was proposed to make use of a Dutch supplier (IDA).

Finally the project was approved for (X-Ray) equipment in several districts, "only", without strengthening the national receiving structures: a missed opportunity. For the enterprise it was easier to settle ORET financing for the equipment without, rather than accompanied by technical assistance.

Operational issues

- In Low Income Countries, the import capacities should be strengthened to ensure that the investments are used in an appropriate, economical, effective and efficient way.
- If DGIS is serious about its wish to develop partnerships with private initiatives and to make these "relevant for development", it should become more pro-active.
- Private initiatives are more prone to attempts of corruption in recipient countries, this would be something new to DGIS interventions and DGIS should be prepared;
- Supply services for essential drugs should be recognised as part of a Dutch public-private mix;

Turkey

For the Van Region, along with the Turkish Government a programme was developed and proposed for co-financing by ORET. This 40 Million Guilder programme contained, besides the delivery of medical equipment, a significant portion of health system development. The latter included strengthening management and planning, human resource development (a conditionality to obtain ORET financing) and strengthening primary health care in the referral system of the hospitals to be supported.

The process of obtaining the approval for the ORET financing took a **long time** – more than three years after the first proposal was submitted. It was not easy for the Turkish Government to accept the ORET conditionalities, for example the restrictions on how its counter payments could be

financed – it was not permitted to use World Bank loans. Possibilities for **cluster financing** were explored without positive results. At the Task Force side it was not always easy to meet the ORET condition of a minimum of 60% Dutch goods in the project proposal. Also, new conditionalities kept appearing during the process, each of which had to be renegotiated with the Turkish Government. The "sense of ownership" of the project among the Turkish partners was often challenged this way. During this extended period of project approval, political changes took place in Turkey which made it necessary to return to the negotiating table. And then, to top it all off, two earthquakes occurred in the country- just after the ORET agreement was signed in The Hague. Again the momentum was lost, and in the end no project could be signed.

Operational issues

- If DGIS wishes to add the value of relevance to development to this kind of private initiative, it should also be prepared to finance the technical assistance that necessarily accompanies those investments during the pro-active part of the process.
- DGIS and EZ could consider the possibility to adapt the instruments in such a way that the delivery of goods is accompanied with the delivery of services.
- DGIS and EZ might attempt to simplify the procedures for procuring an approval for ORET.
- DGIS and EZ might reconsider the possibility of "cluster financing" with the World Bank to support these kinds of activities.

Thailand

Between the MOHP and the task Force a Memorandum of Understanding was signed. This was sufficiently important for the Thai Government to ensure the attendance of the highest ranking decision-makers of the MOHP at the signing ceremony in Amsterdam. Interesting to observe at this event was the explicit statementof the MOHP that, in principle, the **demand was for "software"**, not for hardware. This, because Thailand had already invested too heavily in equipment and buildings in a period of impressive economic growth, and a period of collapse had just gotten underway.

For that reason there was more interest in strategies to make a more efficient use of the existing infrastructure, like human resource development, health reform, decentralisation, insurance systems, tier payment systems, accreditation and health management information systems. Besides that there was also interest in developing strategies to make a more efficient use of medical equipment like health technology assessment, maintenance systems, equipment planning systems. For the equipment manufacturers this meant an opportunity to build up a long-term client relation, so they supported the pro-active activities of the knowledge institutes.

Since the signing of the MoU, different missions have taken place to Thailand to reach an agreement on a first activity plan to be undertaken in the context of this MoU. This plan was submitted for approval for a PESP financing. Although this plan was met with a lot of sympathy from EZ, the fact that the majority of the activities addressed "services" and not "goods" meant that it could not be accepted for PESP. The private enterprises in the Task Force decided to re-write the proposal in such a way that "goods" prevailed over "services". Although in this way the PESP-financing was obtained, the Thai partners could no longer recognize their demand in the new plan. The MoU is now asleep.

It should be mentioned that also in Egypt an MoU is about to be signed, which concerns a similar type of demand: support for health reform, including the national insurance system. So there is a clear demand for more Dutch products to be exported than equipment alone.

Operational issues

- A demand for import of Dutch services (including those regarding the Dutch health financing system) does exist, but:
- EZ-instruments (such as PESP) are not applicable for the export of services;
- Non-for-profit organizations do not possess sufficient financial means to finance long pro-active activities and should be supported during these periods just as the "hardware" companies are (e.g. by a PESP). This may be motivated by the fact that they "export" services – and services are the main export item of The Netherlands;
- Conditions, enterprise cultures, socio-economic conditions, expectations in low and mid-income countries are different. There is a need to "bridge" the export of existing Dutch services to these countries by experienced knowledge institutes.

CONCLUSION

It is generally acknowledged that investments in health are key to the development of low and mid-income countries. To improve the health status, health services are in need of proper equipment to enable the right diagnoses of diseases. Medical equipment is essentially produced and supplied by private enterprises – these represent for that reason an interesting opportunity to study the mix between public and private sectors.

As the purchasing power in these countries is limited, it may be justified to support them financially in purchasing this type of equipment. Conditions are different in these countries, for example because there are fewer possibilities to come to an informed choice than in western countries. For that reason it is not advisable to apply the normal EZ type of regulations for export stimulation. Certainly if this is (partly) funded by DGIS, in which case a balance has to be found between these criteria for the support of private initiatives in EZ and in those in DGIS that are related to relevance for development. This is less contradictory than may seem at first sight. It may even increase the coherence between the activities of two departments of the same government in the perception of foreign (recipient) countries.

Asking private enterprises to pursue development objectives is in many ways a tall order, in part because they lack the necessary capacities. They are by nature "demand-driven", and react to the demands of decision-makers; the demand they respond to is not necessarily based on local health needs. Knowledge institutes are experienced in acting on the different conditions present in low and mid-income countries – they are used to strengthening import capacities and absorption capacities in these countries. They work to strengthen the receiving structures by improving their management and planning capacities, by developing tools like management information systems, or by supporting human resource development: providing training, but also developing tools for pursuing a right-sizing and right skills-mix of personnel in health facilities, and tools to improve their performance. Knowledge institutes can support the identification of health needs and then translate them into demand, which could lead, for example, to a more appropriate allocation of equipment at each level of the referral system. They are experienced in working within the local institutional framework and can bridge cultural differences and increase institutional sustainability.

Voluntary initiatives have spontaneously arisen between private enterprises and knowledge institutes that have the above-mentioned capacities. The Task Force is a good example of such a collaboration. Private industry is open to collaboration with knowledge institutes and is open to making its equipment more development-oriented. Moreover, this is a good public relations opportunity, providing a comparative advantage over competitors without this type of service.

Financial instruments like PESP and ORET motivate private enterprises to offer comprehensive packages. Whenever it is difficult to supply the whole package, they prefer to sell their equipment without technical assistance and without relevance for development. And they can't be blamed for this, particularly if they already invested pro-actively.

These instruments should be re-assessed. If DGIS and EZ are serious about promoting a public-private partnership as was laid down in the Dutch governmental policy, then an implementation policy must follow. The departments need to be predictable in how they implement their instruments. The departments could be more pro-active, or support public-private partners in the pro-active phase of their activities. They could simplify the procedures of these instruments, as their practical complexity often results in a loss of momentum. The provision of services should also be regarded as a type of export. If DGIS is seeking relevance for development then it should seek to ensure that activities that address this goal are included in the package. And it should make clear how these kinds of activities will be monitored, and for what kind of results they will be held accountable.

In this way, export stimulation may turn into a strengthening of import capacity - which will probably boost exports - and ensure a sense of ownership and therefore sustainability.