

# Global Public–Private Partnerships in Primary Care: Navigating Equity Tradeoffs

Emmanuel Iyanuoluwa Ajanaku<sup>1</sup> , Adeyinka Samuel Eniyewun<sup>2</sup>, Taiwo Rukayat Onifade<sup>3</sup>

Correspondence: Emmanuel Iyanuoluwa Ajanaku (ajanakuiyanuoluwa01@gmail.com)  
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## Abstract

The global rise in young-onset cancers (cancer among individuals under 50) has emerged as an unexpected and unsettling trend. While cancer has long been considered a disease of aging, new data suggest that colorectal, breast, pancreatic, and gastric cancers are increasing in incidence among adolescents and young adults across high- and middle-income countries. According to Global Burden of Disease (GBD) 2019 estimates, colorectal cancer incidence has increased by over 15% among individuals aged 20–39 in the last two decades. The incidence of new Pancreatic cancer diagnoses in people under 50 has risen by 79% in the last 30 years. Early-onset breast cancer has risen steadily in regions of East Asia and North Africa, while pancreatic and endometrial cancers are rising among young adults in Europe and Latin America. This global increase is posing a challenge for public health. Therefore, this review explores different factors behind rise in young-onset cancers focusing particularly on environmental exposure, alteration in human microbiomes, and data gaps in present surveillance systems. Early-life environmental exposures such as air and water pollution, endocrine-disrupting chemicals, ultraprocessed foods, and chronic low-grade inflammation from sedentary lifestyles or obesity are increasingly implicated as key drivers of cancer risk later in life. Alterations in the composition, diversity, and function of gut flora termed dysbiosis have been linked to colorectal, pancreatic, liver, and other cancers. The lack of disaggregated cancer data by narrow age bands and the limited availability of screening for younger populations prevent early detection and targeted prevention. The review calls for enhanced surveillance frameworks, longitudinal cohort studies, investment in onco-microbiome research, and reforms in screening policy. Environmental justice, and scientific equity is essential to addressing this alarming trend and mitigating its long-term impact.

## Keywords:

## Reframing Public–Private Partnerships in Primary Health Care: An Equity Lens

Public–private partnerships (PPPs) have become a defining feature of the global health landscape, especially as governments seek to mobilize diverse resources to meet the ambitious goals of Universal Health Coverage (UHC). Their increasing incorporation into Primary Health Care (PHC) systems, particularly in Low- and Middle-Income Countries (LMICs), represents a major departure from their historical roots in disease-specific vertical programs. This transition demands a more critical and nuanced appraisal of how PPPs interact with health equity imperatives. While PPPs

may offer avenues for innovation, efficiency, accessibility, and expanded service delivery, they simultaneously risk worsening structural inequities, displacing public investment, and fragmenting care. This commentary explores the core equity trade-offs inherent in PPPs for primary care, highlighting gaps in current governance frameworks, the implications of market-driven approaches, and the need for equity-centred policy design

## Transitioning PPPs from Targeted to Systemic Approaches

PPPs have delivered notable successes in global

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health, particularly through vertical programs targeting infectious diseases. Flagship initiatives like the Global Fund and Gavi exemplify how strategic alliances between public and private actors can marshal resources and deliver life-saving interventions at scale [1]. However, the horizontal integration of PPPs into PHC, a foundational component of health systems, poses complex challenges. Unlike vertical programs, PHC involves continuous, comprehensive, and community-embedded care. Its delivery is inherently relational and place-based, making it less amenable to commodified or standardized interventions.

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### **Allocative Equity and Budgetary Risks in PPPs**

Equity trade-offs are further complicated when PPPs consume a disproportionate share of health budgets. The Lesotho example is particularly instructive. There, a PPP model delivered a high-quality national referral hospital, yet the project absorbed nearly half the national health budget, thereby constraining investment in rural and preventive services [7]. This case raises critical questions about allocative equity: Should we divert scarce public funds to high-cost, high-tech facilities at the expense of broad-based, community-level services?

Even well-intentioned PPPs can fall short without rigorous mechanisms for transparency, accountability, and public engagement. Nigeria's Saving One Million Lives initiative, which leveraged private sector involvement in maternal and child health, lacked clear accountability structures and equity benchmarks. As a result, disparities in access and quality of care persisted [8]. These experiences highlight the limits of technocratic or efficiency-driven models in addressing the complex social determinants of health.

### **Digital Health Partnerships: Innovation without Inclusion?**

The digital health frontier introduces a new set of equity considerations. While digital PPPs can increase access to consultations and triage services, as seen in Rwanda and Bangladesh, they can also reinforce existing digital divides [9, 10]. Marginalized populations often lack reliable internet access, digital literacy, or appropriate devices, effectively excluding them from emerging modes of care delivery. Additionally, algorithmic bias and data privacy concerns pose further risks to equity in digitally mediated care.

### **Stewardship and Regulation: Key Determinants of PPP Equity Outcomes**

These developments call for robust governance frameworks that can anticipate and mitigate equity risks. Regulatory capacity is a decisive variable in determining whether PPPs serve public interest goals. Thailand offers a relatively successful model in this regard. There, the government has retained strong stewardship over financing and service provision, using private sector inputs in supportive roles rather than as system drivers [11]. In contrast, weak regulatory environments, as found in many fragile or conflict-affected states, enabled private actors to prioritize donor preferences or market returns over population health needs [12].

### **Equity by Design: Rethinking PPP Assumptions**

A key gap in current discourse is the lack of systematic equity impact assessments embedded within PPP design and evaluation. International donors and development finance institutions, as the principal architects and funders of PPPs, have an ethical obligation to ensure that their investments do not exacerbate health inequities. This requires more than tokenistic stakeholder consultations or retrospective evaluations. Equity considerations must be front-loaded into contracting processes, performance metrics, and long-term sustainability plans. Transparent procurement, independent monitoring, and inclusive governance are essential safeguards.

Furthermore, the global health community must reckon with the implications of expanding PPPs in primary care. The assumption that private sector involvement inherently leads to improved outcomes must be problematized. Innovation and efficiency are not value-neutral; they are shaped by the institutional and political context in which PPPs

**Table 1: Key Equity Strategies for Effective Health PPP Implementation**

Key Recommendation Area	Specific Actions/Strategies	Rationale/Expected Impact on Equity	Stakeholders
Prioritize Robust Governance	Mandate full implementation of comprehensive frameworks like TAPIC (Transparency, Accountability, Participation, Integrity, Policy Capacity). Emphasize transparent communication, clear contracts, performance metrics, and genuine participation of all stakeholders, especially vulnerable communities.	Strong governance directly mitigates the profit motive's negative impacts, builds trust, and ensures resources are allocated equitably, leading to services that truly meet community needs.	Government, Policy advocate.
Strengthen Public Sector Capacity	Invest significantly in building the public sector's capacity for PPP negotiation, contract management, monitoring, and evaluation in LMICs.	Addresses the "capacity gap" that often leaves LMICs vulnerable to unfavorable PPP terms and ensures effective oversight, leading to better value for public funds and more equitable service delivery.	Universities, National Governments, International Agencies
Context-Specific & Equity-Driven Design	Tailor PPPs to specific local contexts, explicitly designing them with an equity lens from inception. Address the unique needs of rural, indigenous, refugee, and low-income populations, incorporating culturally sensitive approaches and patient navigation services.	Ensures PPPs are not superficial fixes but address the unique barriers faced by marginalized groups, leading to targeted and effective improvements in access and outcomes.	Government, Civil Society, International Donors
Align Values and Methods	Proactively identify and reconcile potential misalignments between public health goals (e.g., prevention, comprehensive PHC) and private sector incentives (e.g., profit from high-cost services). Prioritize agreement on methods to achieve shared goals.	Prevents PPPs from inadvertently distorting health priorities or increasing costs, ensuring that private sector engagement genuinely supports public health objectives rather than undermining them.	World Bank, Gavi, Global Fund, Bilateral Donors
Increase Public Finance & Oversight	Recognize that increased public finance for health is often the most direct and equitable path to UHC. PPPs should supplement, not replace, public investment, and their fiscal implications must be transparently assessed and managed.	Reinforces the state's primary responsibility for health, reduces reliance on potentially profit-driven private models, and safeguards public funds from excessive costs and risks, ensuring sustainability and equity.	Ministries of Finance and Health
Leverage Digital Health Equitably	For digital health PPPs, explicitly address the digital divide by investing in infrastructure, promoting digital literacy, and ensuring user-centered, culturally adaptable design, alongside robust data privacy and security measures.	Ensures that digital health tools bridge, rather than exacerbate, existing disparities, making technology a true enabler of equitable	Governments, Telecoms, NGOs

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interests. Public financing, participatory oversight, and equitable allocation of resources must anchor all PPP initiatives. Without such commitments, PPPs risk becoming vehicles for commodification rather than conduits for solidarity.

The path toward UHC and resilient PHC systems will be defined by how effectively equity is mainstreamed into public-private collaborations. Governments must reclaim their role as stewards of the public good, ensuring that PPPs do not displace public investment but instead reinforce the moral mandate of health for all. Equity, in this context, is not a passive outcome but a deliberate pursuit, requiring political will, institutional capacity, and normative clarity.

### Authors' Affiliation

1. Health Equity Accelerator Leadership Initiative, Ekiti State University, Ekiti State
2. College of Health Sciences, University of Ilorin, Kwara State, Nigeria
3. Slum and Rural Health Initiative, Ibadan, Oyo State

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### Authors Contribution

Adedeji RT. and Adedeji OA. contributed equally to all aspects of the article, including the conceptualization, drafting, and critical revision.

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The datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

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