Principles of Sustainable Business

Frameworks for corporate action on the SDGs

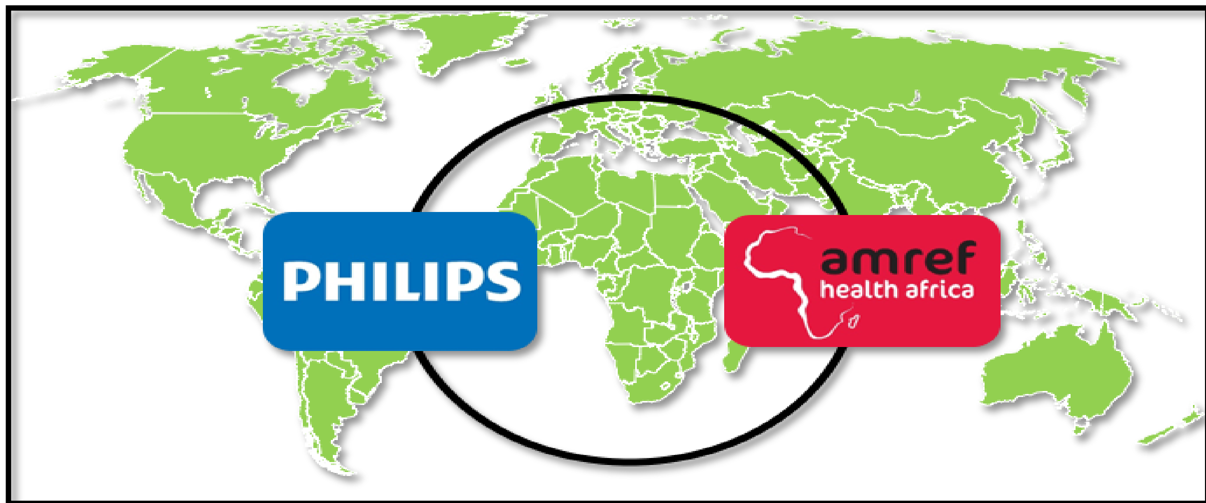
Cases

Making it Collaborative

CASE # 12.8

IMPACT LOOPS 3+4: PHILIPS, AMREF HEALTH AFRICA – ACCESS TO PRIMARY HEALTH CARE (SDG3)

[Relating to Section 12.3.2 of the book – see footnote 8]



THE CASE

Amref Health Africa (known in the Netherlands as Amref Flying Doctors) is the leading health development international NGO in Africa, with 63 years of experience. Headquartered in Africa, it has a presence in 8 countries in Africa and 13 country offices in Europe and North America. Amref reaches more than 12 million people (70% women and children) per year. Its vision is 'Lasting health change in Africa'. As for its mission: "*Amref is committed to improving the health of people by partnering with and empowering communities, and strengthening health systems*." Amref has been developing into a 'hybrid' organization (see Sections 6.3, 8.3 and 8.4 in the book), combining nonprofit and more for-profit activities, in an effort to increase its financial sustainability and ultimate effectiveness in achieving its core mission.

Royal Philips NV is active in the field of health and wellbeing. Philips was founded in 1891 in Eindhoven, The Netherlands, and has been improving people's lives with a steady flow of ground-breaking innovations. It is present in more than 100 countries. Philips' vision is "to

improve people's lives through meaningful innovation." The company's mission is *"to make the world healthier and more sustainable through innovation*; their goal to improve the lives of 3 billion people a year by 2030, of whom 400 million in underserved communities. Over the years, Philips has developed from a for-profit (equity-based) company to a more purpose-driven company that explicitly aims to serve societal goals as its core value proposition.

In 2013 Philips and Amref Health Africa engaged in a strategic partnership, aiming to improve health access across Africa. Both organizations engaged in a wide variety of financial (sponsoring) and instrumental partnerships. After three years, in 2017, the mixed-experience of the thus created partnership configuration prompted both organizations to redraft their partnership and search for ways to enhance their impact and make the partnership more strategic for both organizations. This process led to a second co-creation workshop in September 2017 in Nairobi, followed by the renewal of the partnering agreement between the two organizations in 2019, and the conception of a new 'Theory of Change' for the partnership for the 2020-2023 period and beyond.

THE CHALLENGE

Access to primary health care as a 'wicked opportunity'? Access to affordable and quality healthcare continues to be a persistent global issue, with some 3.8 billion people worldwide lacking access to basic healthcare. Particularly in Africa, this access is still insufficient due to undeveloped health systems, with 50% of the African population suffering from a lack of access to essential healthcare. In addition, for 100 million people accessing the necessary healthcare means being driven into poverty. Access to Universal Health Coverage (UHC) is one of the targets of SDG3, whilst access to primary healthcare is considered the most efficient and effective strategy for achieving UHC.

The problems and causes associated with access to primary (health) care is well covered as a complex problem in WHO and other studies. Most of the challenges included in the SDGs are 'wicked': systemic in nature, complexly interrelated, and materializing at the interface between public-private and profit-nonprofit interests. They are often prone to 'politization' of the problem by interest groups and various societal stakeholders. However, access to primary health care has also been identified as one of the most promising growth areas for companies ('wicked opportunity'), provided that proper arrangements can be created and appropriate technology developed. Addressing wicked problems cannot be done through simple or technological solutions alone. A multiple-stakeholder approach is, therefore, not only part of the problem but also a vital part of the solution.

INCREASING RELEVANCE OF PARTNERSHIPS AND CO-CREATION

Over the years, Philips has been developing from a (consumer) products and technology-driven company into one aiming for 'systems approaches'. Philips was one of the companies that embraced the SDGs immediately. It chose SDGs 3, 12, and 13 as key areas for further development and also structured its reporting around the achievement of these goals (and the nexus with other goals and targets). In developed countries, this strategy proves relatively easy, but in developing countries – at the so-called Bottom of the Pyramid – the challenges

are more formidable and more needs to be done. Accordingly, engaging the community in a process of co-creation to ensure the appropriateness of the company's value proposition in the local setting, became a key aspect of Philips' (inclusive) business strategy in developing countries. As one Philips employee states: "*If we really want to improve healthcare…we need to talk to the community, and truly understand their health-seeking behaviours before we look for solutions.*" One of the pioneering pilots in which Philips engaged in Africa was the creation of 'Community Life Centres' (CLCs). Philips' approach of choice included a participatory-based needs assessment, conducted within the targeted communities in which potential solutions were co-developed with local stakeholders – including country and national governments that are also necessary to create complementary support systems, take responsibility of staffing, and secure a regular drug supply.

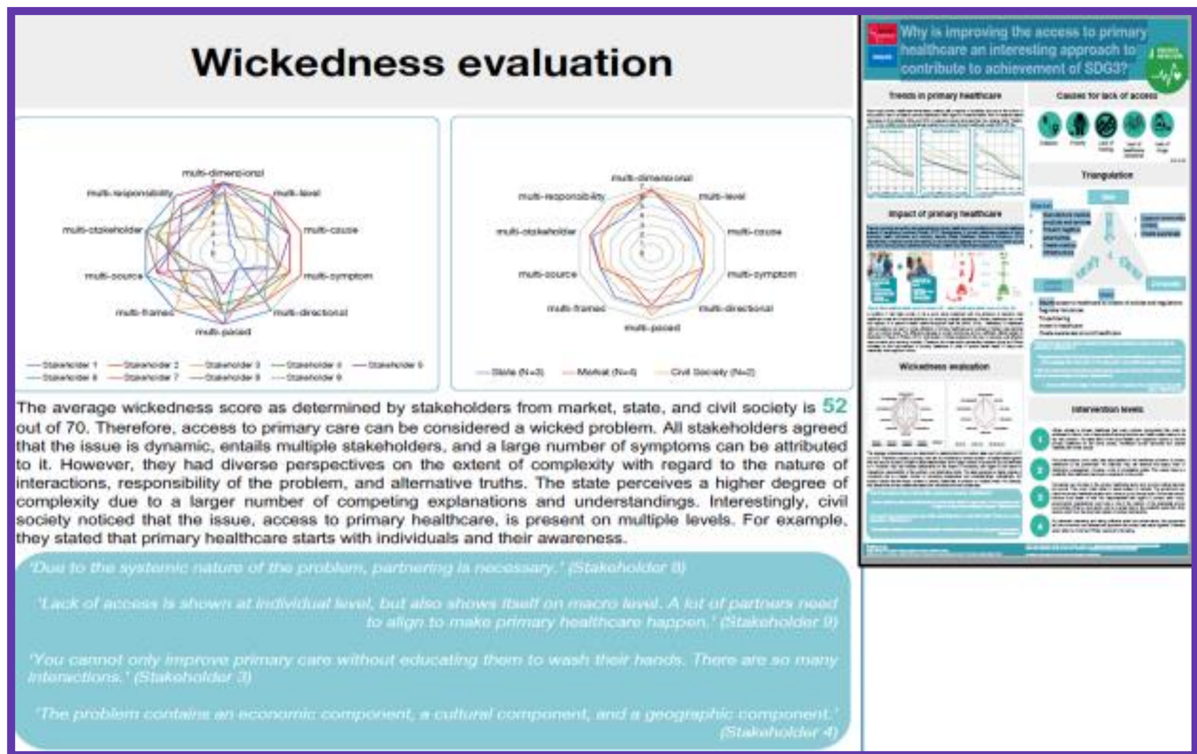
Moreover, as Philips was not yet very familiar with operating at the Bottom of the Pyramid, partnerships with civil society and multilateral organizations gave the company access to low-income and vulnerable communities. These cross-sector partnerships provided Philips with legitimacy. As one employee recognizes: "*Many people have a predisposition when it comes to for-profit businesses operating in the field of development. Especially in health care, which is seen as a public good, there can be some animosity towards the private sector. Working with NGOs helps us to gain a 'license to operate' in this sector*". Philips also recognized that many donor organizations require partnerships with a non-governmental organization as a precondition for providing development funding. Being engaged in a multi-stakeholder network provided funding opportunities that the company could not have accessed alone for environments that the company might find too risky. Finally, cross-sector partnerships made a new set of capabilities and expertise available to the CLC, which could be harnessed to address the needs of the community outside of the scope of the business – such as water and sanitation programs or training on specific medical capabilities.

In order to structure its partnerships, Philips conducted a primary healthcare ecosystem mapping exercise based on the capabilities, geographical reach, and strategic fit of potential partners. In doing so, the company distinguished between 'strategic' partners and 'supporting' partners. Strategic partners are organizations that have a broad set of capabilities and a wide geographical scope. Consequently, they included Amref Health Africa – the largest CSO in Africa dealing with health care – and the United Nations Populations Fund. Research and knowledge organizations active in particular countries or with specific expertise became partners during the start-up phase and were identified as supporting partners. This ecosystem approach allowed Philips to focus its partnering efforts and manage risks for the venture. It also allowed Philips to design a portfolio of partnerships that would suit its ambition to not only consolidate a 'license to operate' (level 2), but also to scale its activities toward new markets (level 3) and obtain a 'license to experiment' in partnerships (level 4).

ZOOMING IN ON SCALING AND IMPACT: WICKED PROBLEMS ANALYSIS

Within this portfolio, Philips' partnership with Amref Health Africa (particularly in Kenya and Ethiopia) became the most extensive and most promising. However, after five years, both parties also agreed that the partnership had developed a rather broad portfolio of activities, which required considerable rethinking in order to preserve and increase its efficiency and effectiveness. Improving and upscaling the partnership required both parties to go back to the

drawing board. The portfolio of projects both organizations had started faced some challenges, partly due to two factors: (1) the issue of aligning the cultures and ambitions of both organizations, and (2) the challenge of linking the partnership configuration to the actual degree of ‘wickedness’ of the problem. In particular, ‘access to primary health care’ (SDG3) required a rethinking of the opportunities that could be seized by an improved set-up of the partnership. Hence, a co-design workshop was planned in 2019 for which, amongst others, a wickedness analysis was made with several representative stakeholders inside and outside both organizations. This exercise resulted in the following ‘wickedness evaluation’ – and related poster.



The assessments of representatives of civil society, government, and industry showed considerable overlap, with an average ‘wickedness score’ totaling 52. The conclusion drawn from this exercise: complex problems require sophisticated partnering solutions that include a large number of stakeholders. In other words: an ‘undershooting’ of the partnership – developing overly simple solutions for a far more complex problem – would present a real danger to the partnership’s efficacy (see section 5.5.3 and Figure 5.8).

A stakeholder mapping exercise furthermore uncovered missing stakeholders, yet also revealed that the present partnering configuration still held great potential and willingness to continue and upgrade the collaboration. Taking the next step would require a reformulation of the mission of the partnership as well as an adjustment and further upgrading the partnership’s Theory of Change (ToC). All parties acknowledged that this should be a dynamic process. The ToC should be used to further navigate the partnership toward a common vision on how to deal with access to primary health care in challenging conditions. If organized properly, the experience of the partnership in Kenya could then be scaled to other countries in which both organizations are represented. With increased insights into the actual societal impact of the

partnership (both local and national), both parties could also scope new partners that might further enhance the partnership.

PARTNERING PRINCIPLES

An important step in the upgrading of the partnership was to specify several principles that both organizations agreed upon. Some of these mutually acknowledged principles included the following statements:

- "We believe that the private sector (both for-profit and not-for-profit) has a critical role to play in achieving Universal Health Coverage."
- "We believe in the complementarity of companies and NGOs in general and our organizations in particular. Through our collaboration, we will both learn and improve."
- "We have an obligation to each other to accomplish tasks responsibly, with integrity, and in a relevant and appropriate way. We will make sure we commit to activities only when we have the means, competencies, skills and capacity to deliver on responsibilities. We make clear agreements on how roles and responsibilities are divided between us."
- "We are a learning coalition. We invite colleagues and external stakeholders with different cultures and perspectives to help us sharpen our ideas and learn with us and from us and help improve."
- "We create our own path, are entrepreneurial, and do what we believe in to improve health in Africa with positive energy"

This reappraisal and calibration exercise resulted in an upgraded Theory of Change (ToC) to guide the partnership in the 2020-2023 period, as well as the initiation of an 'impact team' in which individual participants of both organizations keep track of the various phases of learning, implementation and impact (see section 12.3.2 and Box 12.9 in the book).

In conclusion, the Philips–Amref partnership provides a telling example of a 'learning approach' towards partnering, in which both organizations are (a) actively seeking how to effectively address institutional voids, (b) by using their complementary capabilities, (c) to raise impact, (d) while at the same time reinforcing the ambition, goals and objectives of their own organizations – Philips with a clear vision on SDGs 3, 12 and 13 and the company' milestones to be achieved before 2030, and Amref Health Africa with the ambition to raise its effectiveness and financial sustainability by becoming more of a 'social enterprise'.

CASE QUESTIONS

- **Issue-partnering fit**: Evaluate the extent to which you think the chosen partnering principles do justice to the 'wickedness' of the problem. What 'alignment problems' do you anticipate in terms of an 'overshooting' or 'undershooting' of the partnership (see section 5.5.3)?
- **Impact team**: Both organizations decided to create an impact team so as to enable the partnership to develop and learn from gained experiences. Design a 'stoplight' system

with proper 'guiding questions' for each phase of the partnership (consult Box 12.9 in the book).

- **Partnership portfolio management (PPM)**: Can you position this particular partnership in the cross-sector partnership portfolio of both Philips and Amref? Use their websites and (annual) reports to map their full portfolio of issues and partnering relations, and ask yourself whether further strategizing for a greater SDG-partnering fit is possible (consult Figure 12.4 for mapping, and section 12.4.2 for strategizing).
- **Internalization and scaling challenges**: Both organizations are faced with the dual challenge of not only effectively managing the partnership itself, but also making sure that 'learning effects' derived from the partnership are optimally 'internalized' within each organization – in order to make the experience 'scalable' towards other regions, products and perhaps even related sustainability challenges. In that regard, what pointers do you deem relevant for each organization? (see section 12.3).
- **Governance challenge**: both organizations are on the way to become more 'purpose-driven' and more 'efficient'. In terms of hybridity, what does this imply for the governance logic and societal positioning of both Philips and Amref (see section 6.3 and Figure 8.1) ? And what are the implications in terms of for-profit and non-profit 'business cases' (see sections 8.4 and 8.6).
- **SDG-aligned 'sustainable corporate story'**: What would you consider key elements of a 'sustainable corporate story' for both Philips and Amref that convincingly conveys the SDG ambitions of each? (See section 10.6 and Table 10.8).

FURTHER READING

Amref-Philips Partnership for Primary Care website: https://amref.org/partnershipforprimarycare/

Amref 'Seven secrets for transformative partnerships', see https://www.amref.nl/actueel/2021/zeven-geheimen-van-transformatieve-partnerships (in Dutch).

Synthesis report "Evaluation Of Philips Community Life Centres Kenya & South Africa, November 2020. https://www.philips.com/c-dam/philips-foundation/knowledge-hub/main-reports/2018.012-main-report-kit.pdf.

Lijfering, S. & Van Tulder, R. (2020). 'Cummunity Life Centres for inclusive healthcare in Kenya'. In: Inclusive Business Models in Africa. A business model perspective, pp. 25–33. https://www.inclusivebusiness.net/node/5180.