



# Global Health Partnerships

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The UK contribution to health  
in developing countries

Summary and Recommendations

Nigel Crisp

## Acknowledgements

I am very grateful to a very large number of people who have provided me with information, advice and help with *Global Health Partnerships*. A small team of people have supported me expertly and enthusiastically on this review: Imogen Sharp, who took over as Project Director and has worked closely with me and guided the work over the last eight months; Simon Robbins who started the project off so effectively; and Amy Gardiner, Llinos Bradley and Ian McKendry who worked on the project at different times.

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Nigel Crisp  
February 2007

# Foreword

Improving global health is clearly in Britain's interest, and the Commission for Africa and the Gleneagles G8 Summit made several commitments on health and health care. The UK has a major role to play.

Against this background, I invited Lord Crisp to carry out a review of how the UK's experience and expertise in health could be used to best effect to support developing countries. Already the government, the NHS, universities and others — including many individual health professionals, some as volunteers — contribute an enormous amount to help improve health and health services in developing countries.

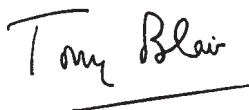
There is no doubt that to meet the health Millennium Development Goals — on reducing maternal and child deaths, and combating AIDS, tuberculosis and malaria — there is a need for a strong health workforce globally. The G8 has promised to help developing countries to fund health care for all. The challenge is for developing countries to draw up ambitious plans — as many have already done. But this will only be possible by addressing the shortage of health workers.

The UK, with other partners in developed countries, has much to offer. The UK government is already providing over £1 billion a year to help Africa tackle poverty — much of it focussed on improving health care, education and water services.

There is also a role here for UK health professionals and UK expertise in health. The NHS has skills and experience that other countries could learn from, and a clear role to play as a global employer of doctors, nurses, other health professionals and managers. This is two way. The UK and its professionals also have a great deal to learn and gain from people in developing countries, particularly in the context of international health challenges.

This new report, *Global Health Partnerships*, sets out many stories of individual and NHS partnerships working to improve health and share learning. Already the UK has an impressive record and reputation on international development, in health and in other areas. But to get the best out of all the enthusiasm and the work that is being done, the report identifies a need for better coordination and more strategic partnerships, and makes recommendations for improvement.

The NHS and health partners have a key role to play in development, and I welcome *Global Health Partnerships* as an important contribution on how this might best be achieved.

A handwritten signature in black ink that reads "Tony Blair". The signature is written in a cursive style and is positioned above a horizontal line.

Tony Blair, Prime Minister  
February 2007

# Summary and Recommendations

In more than five years as Chief Executive of the NHS in England I met many people and NHS organisations that were working – often voluntarily – to improve health in developing countries. Their work seemed to me to be very impressive and very worthwhile.

I was therefore delighted when the Prime Minister and the Secretaries of State for Health and International Development invited me, in March 2006, to look at how we could use UK experience and expertise in health to best effect to help improve health in developing countries.

At the outset we agreed that this review would:

- Be based on countries' needs as identified and expressed by people from those countries
- Aim to add practical value to work already under way.



Nigel Crisp  
February 2007

## The main findings

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We will not see sufficient progress in reducing child and maternal deaths and tackling HIV/AIDS, tuberculosis and malaria – the health Millennium Development Goals – unless:

- Developing countries are able to take the lead and own the solutions – and are supported by international, national and local partnerships based on mutual respect
- The UK and other developed countries grasp the opportunity – and see themselves as having a responsibility as global employers – to support a massive scaling-up of training, education and employment of health workers in developing countries
- There is much more rigorous research and evaluation of what works, systematic spreading of good practice, greater use of new information, communication and biomedical technologies, closer links with economic development and an accompanying reduction in wasted effort.

### The UK

In recent years, the UK has shown remarkable intellectual and practical leadership in international development and espoused a very clear focus on supporting country leadership and local ownership. It can build on this by bringing into play UK experience and expertise in health and the related fields of education and research through:

- Recognising the very valuable work already done by so many UK organisations and individuals, voluntarily and personally, in supporting health services and promoting health in developing countries
- Facilitating and supporting this – helping it to become even more effective
- Making use of it strategically – building strong national and local partnerships around health and making improvements more sustainable
- Drawing on particular UK experience and expertise in:
  - public health and health systems
  - education and training
  - and in making knowledge, evidence and best practice – derived from high-quality research – accessible to health workers, policy makers and the public alike.

In doing so the UK can:

- Learn a great deal for itself about how to meet its own health needs
- Broaden the education of health professionals in the UK
- Build stronger relationships across the globe that will stand the UK in good stead in a changing and risky world.

## What people told me

I started working on *Global Health Partnerships* by listening to what people from developing countries told me themselves about their needs. I am privileged to have been able to meet some 15 ministers of health, visit a number of countries and talk to a wide variety of local people.

I have concentrated on Africa and India but also had some contact with people from other parts of Asia, China and the Caribbean.

Each country is unique but all share common issues. They all face desperate health problems – awful disease, early death, few resources. These are compounded by environmental and social issues – lack of clean water and good sanitation, poor education, poverty and inequality and, sometimes, corruption and violence. In addition, all have difficulty in retaining health workers, many of whom migrate to developed countries, move into other occupations or, in the case of rural workers, move to the cities. In many countries, AIDS has taken a heavy toll on health workers.

### The contrasts with the UK are stark

Child deaths under five: in Sub-Saharan Africa, 179 in 1,000; in UK, 6 in 1,000

Life expectancy for a woman: in Sub-Saharan Africa, 46; in UK, 78

Annual health expenditure per person: in Sub-Saharan Africa, \$36; in UK, \$2,508<sup>1</sup>

Everywhere I went people told me they were keen on greater partnership and links with the UK, sometimes built on our shared history and tradition. They want – and need – more funding for health, but they also want to draw on UK experience and expertise in health and to work together in a spirit of mutual respect around three main areas:

### Where people thought UK experience and expertise could help

- Strengthening public health, health systems and institutions
- Providing education and training for health workers – and retaining the ones they have
- Making knowledge, research, evidence and best practice accessible to health workers, policy makers and the public alike

However, in working together in this way we need to be very sensitive to environment and culture.

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***They want – and need – more funding for health, but they also want to draw on UK experience and expertise***

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The most pressing needs in developing countries are for balanced and integrated health systems with a particular emphasis on public health and primary care, not hospitals and tertiary care, although these have their place. Providing healthcare to a needy population with an average total expenditure (public and private) of \$36 a person each year – and a range going down to around \$5–\$10 in parts of Africa and India – is very different from providing for an affluent population in a developed country.

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***Ultimately, leadership is local and Africans will sort out Africa's problems.***

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There are also cultural issues – things are done very differently in different countries. You cannot simply apply UK methods and behaviours. This is not about giving people a UK **product** but about a process of **working** together to meet a need.

There are also sometimes difficulties in the way developed country organisations and individuals behave. Programmes dealing with single diseases – the so-called 'vertical programmes' – can inadvertently damage wider health services; migration to developed countries has helped weaken health services; there is resentment of uncoordinated aid and the burdens it brings, and anger at some high-handed 'northern' behaviour and assumptions.

International leadership is needed not only to mobilise resources and provide impetus and expertise to support developing countries. It is also needed for us all in a rapidly globalising world with far greater economic, social and physical interdependencies.

Ultimately, however, leadership is local and *"Africans will sort out Africa's problems"*.

## The wider picture

There has been an enormous international effort over recent years to address these issues. Governments acting alone, or in international partnerships, have initiated programmes and made funding available. New philanthropists have emerged; fast-growing countries like India and China have become aid givers and international investors; the European Union (EU) and EU countries have become major donors alongside the USA.

Remarkably, some 189 countries have signed up to a set of 8 shared targets – the Millennium Development Goals. Those directly related to health – reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria and tuberculosis – have become the main focus of international efforts in health.

At the same time, the numbers and range of activities of non-governmental organisations (NGOs) have grown, providing advocacy and services around the world. They have connected with a growing public awareness, manifest in the *Make Poverty History* campaign.

The UK Government is one of the world's leaders in international development, both as a donor – it is the largest single donor in Africa – and as an influence on international policy and action. Its leadership within G8 on commitments on Africa and the Commission for Africa, its work with global partners such as the World Health Organization and its progressive stances on trade and climate change are well recognised internationally.

The UK has also developed its international role in health in recent years with active collaborations with a number of countries over issues as varied as health protection, health security, policy development and trade. Several of its agencies – such as the Health Protection Agency (HPA) – play important roles internationally. Bringing all these initiatives together, *Health is Global: Proposals for a UK government-wide strategy* is a report designed to position the UK for dealing with health in a globalising and joined-up world.<sup>2</sup>

UK institutions have a long history of involvement in health in developing countries, stretching back into colonial times. The London School of Hygiene and Tropical Medicine was established in 1899. It contributes with many others – such as the Liverpool School, the leading universities and the Overseas Development Institute – to the UK's excellent academic record in this area. They have been supported by the Medical Research Council, active in tackling infectious diseases for several decades, and the Wellcome Trust, a major funder of research on international health.

Many major UK NGOs – Oxfam, Save the Children, the British Red Cross, Care, Christian Aid, Merlin, Plan, Action Aid, and Sightsavers, for example – play leading roles internationally. There are thousands of smaller voluntary organisations and more than 100 links between NHS organisations and their associated academic partners with organisations in developing countries.

This discussion of current UK activity needs to be seen within the wider historical picture. I have been told and seen evidence of any number of well-intentioned initiatives that foundered after a few years – or had their funding withdrawn – or that were simply misguided and ineffective and where all their gains evaporated quickly. There have been many earlier efforts to reform and improve.

This can lead to cynicism and a counsel of despair that “*despite all the effort over the years, nothing has really changed and nothing will really change*”.

There have undoubtedly been improvements. The UK and other donors as well as NGOs and advocacy groups can rightly point to a whole range of successful programmes in health, education and other areas. Many ‘developing countries’ are growing fast economically and becoming important ‘emerging markets’. There is a renaissance in Africa – with less conflict, more stability and more growth.

But progress is not fast enough, widespread enough or secure enough.

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***There are thousands of smaller voluntary organisations and more than 100 links between NHS organisations and their associated academic partners with organisations in developing countries.***

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***Many ‘developing countries’ are growing fast economically and becoming important ‘emerging markets’.***

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The key question is to ask what needs to be done differently. All this new money, international attention and goodwill provides the opportunity, but what will we do differently this time to ensure that we don't just get the same results as we have always got?

Recent reviews of the Millennium Development Goals show indeed that progress in some areas is slow and demonstrate the difficulties inherent both in the task itself and in maintaining alignment and focus among so many partners.

I argue in *Global Health Partnerships* that there needs to be changes in the international approach if we are to achieve the Millennium Development Goals in health. However, I also recognise that there has already been a remarkable set of changes that are creating a much more positive and hopeful environment:

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**... education and empowerment – particularly of women – and helping people have more control over their lives and environment have profound and lasting effects.**

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- The UK Government, through the Department for International Development (DFID), is emphasising long-term aid, support to countries themselves to tackle their problems through direct budget support, improvements in governance and innovative ways of providing support for research and investment. It is pressing for better international organisation with more coherent and less fragmented and burdensome aid agreements.
- No amount of aid should obscure the fact that, as a recent Oxfam and Water Aid publication<sup>3</sup> pointed out, it is a government's own responsibility to ensure that its people have the basic services of education, water and health. Greater clarity and transparency in international arrangements will help.
- It is not just about governments. There is now a great deal of evidence that education and empowerment – particularly of women – and helping people have more control over their lives and environment have profound and lasting effects.
- Trade and commercial interests are opening up opportunities, while microcredit and the energy of local entrepreneurs are creating new sustainable activity and helping empower local communities and individuals. "Growth," as the Government's latest White Paper<sup>4</sup> says, "is the best way to reduce poverty."
- Underpinning all this, there are geopolitical issues of climate change, economic development and security that are beginning to drive changes in international relationships which will – for good or ill – influence the health and well-being of people in developing countries.

## UK experience and expertise in health

Against this background, I have reviewed the experience and expertise of the NHS and its partners – in health, education and research – to look for practical ways to support health and health services and systems in developing countries.

This has involved talking to people in all parts of the health system – members of the public, health workers and volunteers – as well as education and research

providers, NGOs, commercial organisations and UK institutions such as the BBC and British Council, and many international organisations such as the World Health Organization, the World Bank, the Commonwealth Secretariat, the World Economic Forum, UNAids, the Global Fund and others.

The result is that I have identified a wide range of areas for greater contribution, most of which will have some element of mutual benefit.

In looking at potential contributions, I have borne in mind that the UK Government approach is to focus on eradicating poverty and to do so, wherever possible, by supporting a country's own plans – a 'country-led' approach.

It has moved away from supporting individual projects towards a more strategic and comprehensive approach. It no longer provides much technical assistance and does not tie aid to any requirements, for example, to use UK suppliers.

UK health experience and expertise could be made available to support this through three routes:

- Commercially, with UK suppliers bidding to provide technical support or other services
- As an integral part of the UK's development activity, with DFID staff able to draw on advice and help from health organisations and people
- In partnerships and collaborations, voluntarily entered into between organisations and institutions.

The commercial route is important. There are many good UK organisations that provide technical support commercially and one of them, HLSP, provides a health resource centre service to DFID.

Universities and other bodies provide consultancy services and will undoubtedly want to contract to supply education and training. Some NHS bodies engage in joint ventures and commercial activities within their powers. DH International was established precisely to promote UK health experience and expertise commercially.

*Global Health Partnerships* is primarily concerned, however, with the other two routes.

My observation from meetings with people in developing countries is that there are many times when they may be looking for advice or help or interested to talk with people who have handled the same problem elsewhere. They may want occasional input or, perhaps, a substantial and longer term relationship with, for example, the HPA.

Over the next few years, as DFID's expenditure grows but its staff contracts, it will need to be able to access current high-quality expertise in all aspects of health from outside its own organisation to provide this sort of input. The recommendations here provide a framework within which it could do so.

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***... there are many times when they may be looking for advice or help or interested to talk with people who have handled the same problem elsewhere.***

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There are already very many partnerships of different kinds in existence. The recommendations here are designed to help develop and support partnerships that fit within country's plans, respond to their needs and enhance UK support.

I have been aware of the need not to impose extra burdens on staff in DFID or developing countries. These recommendations propose new and easier ways of accessing health expertise and use intermediary bodies – such as VSO and The Tropical Health Education Trust (THET) – to do so. Wherever possible, I have built on existing organisations and arrangements.

In order to make these recommendations work, DFID will need to encourage countries to think about what voluntary effort they might want to engage and what partnerships they might want to develop with UK organisations.

I have also been very conscious of NHS resources in looking at how UK organisations can contribute. Many NHS organisations are already – in a planned or unplanned way – incurring costs as their organisation or staff support development work. A number have attempted to quantify both the benefits and the costs, and have agreed specific plans with their boards to support partnerships and voluntary activity by their staff.

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***... the Government will need to decide whether to support and fund this – as it does with schools and education links – as part of its wider development activity.***

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Most organisations – including NHS ones – will be able to fund this activity up to the limit where they believe there is mutual benefit in learning, staff development and the exchange of skills as well as benefits to their reputation. Beyond this, the Government will need to decide whether to support and fund this – as it does with schools and education links – as part of its wider development activity.

## Recommendations and conclusions

This review has convinced me that changes are needed internationally in three areas in order to improve the rate of progress with the Millennium Development Goals.

The first relates to the complicated, confusing – and sometimes chaotic and conflicting – way in which policy is developed internationally and aid is delivered.

Powerful and fast-developing countries like China, India and South Africa can negotiate with donors on equal terms and determine how development takes place and aid money is spent in their own countries. Poorer countries, however, are too often powerless and forced to respond to foreign initiatives.

I was told of a former Mozambique minister of health saying: *“When I was appointed minister, I thought I was the minister of health and responsible for the health of the country. Instead, I found I was the minister for health projects ... run by foreigners.”*

The UK approach of supporting 'country-led' plans, helping improve governance and reduce corruption, and offering long-term agreements on aid provides the right basis for the future. This approach is shared by Canada, Norway, Sweden, Denmark and the Netherlands, among others, but most development agencies now see poverty reduction strategies as the process for furthering country-led development. This country-led approach needs to be reinforced at every opportunity.

The second area is the staffing crisis, particularly affecting Sub-Saharan Africa. The World Health Report 2006 has demonstrated both the scale of the problem and the link between poor health – and unnecessary death – and low levels of trained staff.

There needs to be a powerful and coordinated international response to this. The UK can, and should, play a leading part.

The third area, closely linked to the first, is the absence of any means for sharing good practice and learning between development projects, agencies and countries. There is a great deal of evaluation – and high-quality academic research – but very little systematic application of knowledge and learning from successful – and failed – projects.

There is, similarly, a need for much greater understanding of how new information and communication technology (ICT) and biomedical technologies can be used to best effect. These, together with a greater emphasis on economic development, can make a far greater impact than is currently achieved.

These are now the subject of growing international attention. They are areas where the UK can contribute from its own experience.

The UK can strengthen its contribution in health by making use of the experience and expertise in the country – and the abundant goodwill and enthusiasm that is available to be put to even better purpose.

## Stronger links between health and development

Stronger relationships across government are an essential first step in making more use of UK experience and expertise in health in supporting developing countries.

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### **Recommendation 1**

*There should be greater ministerial oversight of the links between health and development by giving the inter-Ministerial group on health capacity in developing countries a stronger remit to develop joint working, and by supporting this with closer working between officials.*

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This stronger and more focused relationship will fit well with the Government's plans to develop a global health strategy covering the wider areas of health protection, security, policy development and trade as well as international development.

## **Making the UK contribution even more effective and sustainable**

UK organisations and individuals already offer a wide range of services and help to developing countries. They provide assistance in performing clinical tasks, in education, in helping with organisation, in offering advocacy, in providing continuing help or short-term assistance and they collect equipment, text books and money for organisations and individuals. There is a myriad of organisations and thousands of people are involved.

Many organisations want to learn how to do things better and to make sure their efforts are not wasted but maximised. There is obvious scope for better information sharing and coordination, for less duplication and for the sharing of good practice.

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### **Recommendation 2**

*An NHS framework for international development should be created that sets out the principles and rationale for NHS involvement in international partnerships through:*

- *Government ministers affirming support for the involvement of NHS organisations in international development and endorsing a statement of the benefits to the UK and NHS from involvement in partnerships with institutions in developing countries*
- *Setting out the principles that NHS organisations should adopt when working in developing countries and supporting this with a revised publication of the Department of Health's International Humanitarian and Health Work: Toolkit to Support Good Practice*
- *Ensuring that there is someone in each country (or strategic health authority area in England) who has an oversight of international development activity*
- *Asking the Healthcare Commission (HCC) to include the contribution to international development in its annual assessment process.*

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### **Recommendation 3**

*A global health partnership centre should be established – preferably in an existing organisation – as a 'one-stop-shop' source of information for governments and health organisations alike, which would actively seek to make connections and promote and share good practice and learning.*

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**Recommendation 4**

*An electronic exchange should be piloted – the global health exchange, a sort of HealthBay based on the principles of eBay and FreeBay – which could be used to match requests for help with offers. It could be used for equipment, books, work experience, volunteering, disaster relief and finding training or employment; subject to appropriate controls and safeguards.*

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## Supporting individuals to volunteer

There are many health workers in the NHS who want to volunteer or work abroad for a period. This is often difficult because of employment and pension continuity and worries about returning to suitable employment in the UK.

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**Recommendation 5**

*New partnership arrangements with voluntary organisations should be set up to support staff wishing to volunteer abroad for a period and then return to the NHS by:*

- *Reviewing arrangements to improve opportunities and remove disincentives for health workers to volunteer with VSO, and target them on the identified needs of developing countries – for system strengthening, staff training, public health or service delivery*
  - *Negotiating revised arrangements with the NHS Pensions Agency – perhaps based on the pilot in Scotland – to allow individuals who volunteer as part of these arrangements to maintain pension continuity*
  - *Setting up arrangements in each country (through strategic health authorities in England) to ensure continued employment or re-employment for NHS staff who volunteer as part of this scheme*
  - *Considering how to extend these sorts of arrangements to other voluntary organisations.*
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In order to make these recommendations work, DFID may need to state that it values the contribution of health sector volunteers, and could encourage developing countries to think about the use of volunteers as part of their health plans and poverty reduction strategies, and encourage other donors to take a similar approach.

## Responding to humanitarian emergencies

Many UK health workers respond to humanitarian emergencies by volunteering or offering help in some way. They could be enabled to do so most effectively through existing organisations, which can provide induction and appropriate deployment of skilled staff.

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### **Recommendation 6**

*In response to humanitarian emergencies:*

- *A database should be commissioned on which health professionals with agreed competencies could register. As part of registration, employers will be asked to commit to releasing staff provided that reasonable arrangements are put in place to continue local services*
- *The global health partnership centre and global health exchange should be used as appropriate to support this. They could be used to put potential volunteers for the database in touch with appropriate organisations through which they might get induction and training and, in the event of an emergency, be matched with organisations requesting specific help. They could also be used by DFID, the health departments and the NHS as part of a formal arrangement for disseminating information on humanitarian needs at an early stage during international emergencies*
- *The NHS, at country level (or strategic health authority level in England), should assist in and coordinate the release of staff and the cover needed for them as necessary.*

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## **International experience and education for UK health workers**

Many trainees wish to spend part of their training in developing countries. It is important to ensure that any such training or work experience fits in with the developing country's own plans and needs, and does not simply provide an extra burden. There is also a need to make sure that – in the right circumstances – this is properly recognised by training authorities.

There are also a number of people who are working abroad for extended periods who want to maintain their accreditation so that they can return to the NHS.

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### **Recommendation 7**

*In order to enable health workers to gain international experience and training:*

- *An NHS framework for international development should explicitly recognise the value of overseas experience and training for UK health workers and encourage educators, employers and regulators to make it easier to gain this experience and training*
- *Medical, nursing and healthcare schools should work with others to ensure work experience and training placements in developing countries are beneficial to the receiving country*
- *Postgraduate Medical Education and Training Board (PMETB) should work with the Department of Health, Royal Colleges, medical schools and others to facilitate overseas training and work experience*

- *The Department of Health should work with the regulatory bodies and others, as appropriate, to create arrangements for revalidation and accreditation for UK professionals working abroad for long periods but planning to return to the UK.*

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## Strengthening health systems through partnerships and learning

Leaders from developing countries see the strengthening of health systems in very practical terms. They want to know that the drugs and vaccines they buy will reach patients, that staff will be trained and paid and that they are spending their scarce resources on the right things.

They also told me they wanted partnership with UK hospitals, healthcare schools and other providers and they also wanted some links at national level – with those people who design and manage the systems. They particularly wanted their staff to work with people doing similar jobs in the UK – with current ‘hands-on’ experience – and to have the scope for mutual learning and exchange – a shared development.

They, like their UK partners, recognise that these partnerships provide a context in which all sorts of exchanges can take place – one year it might be about infection control; the next about radiography, hospital maintenance or immunisation techniques. These partnerships are about a way of working together to meet changing needs and changing goals.

These partnerships also provide the means through which many people are able to volunteer for short periods – contributing within the context of a wider and longer term relationship.

DFID’s ‘country-led’ policy in turn provides a very good framework for enabling partnerships to work effectively and to address the needs of developing countries.

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### Recommendation 8

*Developing countries, as part of their poverty reduction plans and/or health sector plans, should be encouraged to review:*

- *What sorts of partnerships the country needs and wants, what purposes they will serve and how they will be monitored*
- *With what organisations they want to be linked: whether local service providers, like hospitals; or national bodies; or whether a country wants a series of links with a region of the NHS; or to centre its links around a single large institution, like the relationship between Somaliland and King’s; or a country to country partnership, like that between Malawi and Scotland.*

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These partnerships need supporting both with expertise and advice and with some of their expenses.

THET is receiving DFID funding over three years (2006–2009) to help partnerships develop their wider potential in strengthening health systems, broker new partnerships and promote good practice. THET provides the obvious vehicle to expand partnerships further and channel some core funding to them. It will, however, need some additional funding to cover its own costs and to support an enlarged programme.

Whereas there is obvious enthusiasm for partnerships and some evidence of their impact, there are no international studies that show what impact they can make and how they should best be used.

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### **Recommendation 9**

*To reap the maximum possible international development gains from health partnerships, the UK Government should:*

- *Continue to support THET in its role in developing links between health organisations, working with wider community partnerships and spreading good practice – and review its funding to ensure that it is able to function effectively*
- *Use THET as a vehicle to channel small grants to cover the core cost of partnerships that developing countries have supported as part of their poverty reduction or sector plans*
- *Commission an evaluation of the potential impact of partnerships to understand what works, where and why.*

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Ministers in developing countries have also requested help with the development and management of health systems, and with the sub-systems and arrangements that make them work effectively.

In 2001 the Commission on Macroeconomics and Health<sup>5</sup> advocated increasing health funding to provide a package of basic ‘close to client’ services. It estimated that, among other benefits, this basic package would reduce child mortality by two-thirds, maternal mortality by three-quarters and massively reduce the burden of communicable disease.

Most countries are focusing on how best to get this sort of package of basic health services to their whole population and are supported by the G8 countries’ commitment, including the UK, to support them with this.

This is not a matter of copying UK or other systems – although a significant number of countries have systems modelled on the NHS and many of them do wish to learn from the UK’s history of modernising and reforming the NHS. This shared history provides a good background for working together.

The context, however, is very different in a large number of ways. One example is the relationship with the independent sector.

In many developing countries, the independent sector in all its manifestations – NGOs, faith-based organisations, small and large businesses, traditional healers – is the biggest health service provider. Whereas many countries are developing national or local government-run services, there is enormous scope to use the existing independent services to better effect through setting up systems for regulation and quality control. The scope for improving the services already provided is enormous.

UK systems cannot be directly applied, but the methodologies used, for example, by the HCC in regulation and quality improvement or the Health and Social Care Information Centre (HSCIS) in collecting and using information are relevant. There is scope here, as elsewhere, for joint development and learning.

Organisations like the National Institute for Health and Clinical Excellence (NICE) and the HPA, working in technology assessment and public health, are particularly in demand for advice and help and to share experiences and knowledge. Private companies too are willing to offer help with, for example, logistics and procurement.

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#### **Recommendation 10**

*DFID should meet with representatives of the HPA, the HCC, NICE, the HSCIC, representatives of the private sector and others to review how practically they could help strengthen health systems and agree plans for doing so.*

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## **Tackling the staffing crisis**

The *World Health Report 2006* estimates that there is a global shortage of about 4.3 million health workers – with developing countries, particularly Africa, most affected.

Part of the problem is caused by developed countries recruiting staff, but equally important is the desire of people to migrate to better their circumstances, avoid difficult – and sometimes dangerous – working conditions and find training and employment. There is also considerable internal movement with health workers moving into other employment, rural workers moving to the cities and people moving from core public services to the very targeted single disease programmes and to private practice.

A major part, however, is simply the lack of funding for training and subsequent employment in developing countries.

Many health workers have come to the UK from developing countries to work and to train. The UK introduced international recruitment guidance based on ethical principles in 1999 in order to restrict recruitment to countries where there was a government to government agreement. Increases in UK training in the last few years mean that it has become largely self-sufficient in staffing and therefore

changed immigration arrangements in 2006, making it difficult for health workers to come into the country.

This has been welcomed by many. It has, however, restricted the training available for overseas health workers in the UK. It has also disadvantaged some current overseas trainees and – while this has largely gone unnoticed in the UK – had the effect of reducing the amount of remittances sent home to developing countries.

In the future, with normal patterns of supply and demand, there are likely to be times when overseas recruits will once again be welcomed. More importantly for this discussion, the UK has for many years employed a global workforce and trained many more. At the end of 2005 around 30% of its doctors and 10% of its nurses had received their initial training overseas. It will remain a global employer of health workers.<sup>6</sup>

As a result of this, the UK has faced a number of pressures – calls for ‘compensation’ for staff recruited, requests for continued training and demands to assist people from developing countries to be able to contribute to health in their homeland.

The single most common request I heard, however, throughout Africa in particular, was for assistance with educating and training staff of all kinds: community health workers, clinical officers, doctors, nurses, managers and technicians.

DFID has already responded to the staffing crisis with, for example, an innovative and wide-ranging scheme in Malawi and, in common with other international agencies, recognises the wide range of issues to be tackled – the need for funding to employ staff, incentives to keep them and good manpower planning to ensure that there is an appropriate mix of staff and skills to meet the local circumstances.

I believe this provides an excellent background for the UK to play a significant part in concerted international efforts in the future.

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### **Recommendation 11**

*The UK should support international efforts to manage migration and mitigate the effects on developing countries of the reduction in training and employment opportunities in the UK by:*

- *Using codes of practice, country-level agreements and other means to shape and manage the migration of health workers and encourage all other developed countries to do the same*
- *Continuing to provide, by agreement with developed countries, some training and limited periods of work experience in the UK*
- *Creating exchange programmes for training and work experience for UK and developing countries health workers.*

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**Recommendation 12**

*The UK should assist migrants from developing countries to contribute to health in their home country by:*

- *Enabling migrants from developing countries to return home – for long or short periods – through participation in partnership programmes*
- *Creating an NHS service scholarship programme, perhaps as part of an existing one such as the Commonwealth Scheme, specifically to support service improvement in developing countries. It would be open to candidates from developing countries – resident at home or abroad – over a five-year period while they worked on service development in their own country and developed their own experience and expertise with support from the UK and local institutions.*

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**Recommendation 13**

*The UK should see itself as having a responsibility as the employer of a global workforce and seize the opportunity to help developing countries educate, train and employ their own staff by:*

- *Committing a significant part of the future aid flows already designated for health to create employment opportunities and scale up the training and education of health workers in developing countries*
- *Supporting international efforts to scale up the education, training and employment of health workers in developing countries*
- *Developing plans to play its part effectively in this through:*
  - *bringing leaders in health, education and development together with the relevant government departments to plan jointly*
  - *identifying the areas where it could make the most impact and the organisations and approaches that would be the most effective*
  - *reviewing existing training, scholarship and partnership programmes and enhancing them as appropriate*
  - *considering the incentives for UK organisations to work with trainees in the UK and abroad and amending them as appropriate*
  - *ensuring that immigration arrangements allow for trainees and those seeking work experience in the UK, who have a suitable sponsor, to enter the country.*

## **Making evidence and best practice – derived from high-quality research – available to health workers, policy makers and the public alike**

Digital technology is now much more widely available. Together with developments in biomedicine, it is changing the world we live in. It is important to assist developing countries to benefit from these advances and not miss out, being left further behind in poverty.

India, of course, is a world leader in much of this area and some technologies are becoming widespread throughout the world. There are now many mobile phones and computers in use in developing countries – by November 2006, 177 million Africans owned a mobile phone among a population of some 750 million, and Bangladesh has better network coverage than the USA. These are being put to good use by local entrepreneurs and are already being experimented with to support education and services.

There are also now many small-scale experiments and initiatives using these technologies to improve healthcare, from better information gathering to improved education and providing telemedicine services. There appears to be enormous scope to support rural and remote health workers through these means and ensure latest knowledge is available locally.

There is also interesting evidence of the way in which microcredit schemes improve health and can support the development of health systems. They can provide, for example, mutual insurance systems which can mitigate the, often catastrophic, impact of illness in a family.

As a matter of urgency, all these approaches need to be researched and evaluated, and their lessons applied elsewhere, by:

- Making sure that people working in development understand and take the opportunities to support both infrastructure and innovation in developing countries
- Making up for the lack of capital to exploit the technology through further imaginative programmes such as the Advanced Market Commitments that support development of drugs and vaccines, and through helping to provide the environment in which local entrepreneurs are able to thrive and national and international business to invest.

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### **Recommendation 14**

*The UK should give increased emphasis to the use of ICT and other new technologies in improving health and health services in developing countries through:*

- *Bringing the innovators in digital technology and its application to health together with experienced development professionals to understand the potential impacts and work with international partners to pilot and evaluate applications*

- *Paying particular attention to how ICT, alongside microcredit and other means, can support local entrepreneurs improve health and health services*
- *Reviewing its support for the development of appropriate technologies for health in the UK or in developing countries and considering whether a programme based on the American example of PATH would be appropriate.*

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Sir David Cooksey's review of health research and Sir David King's proposal to establish a high level forum for collaboration on development research in the UK will between them provide a very good foundation for the future.

However, it is not yet clear how they will help address the relatively poor use of research evidence in practice by policy makers and practitioners. It will be very important to ensure that, as DFID develops its research strategy, practitioners are involved in these deliberations and that attention is given to researching how best to apply evidence and to evaluating the impact of interventions in practice.

The UK health system has some relevant experience through the development of 'evidence-based' medicine and the subsequent creation of a National Knowledge Service for the NHS in England, which could help international efforts to create effective knowledge management systems and spread good practice systematically.

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#### **Recommendation 15**

*The UK should, in developing the health elements of its development research strategy, ensure a focus on the practical application of evidence, proven good practice in delivery and the systematic spread of good practice.*

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#### **Recommendation 16**

*The UK should find ways to use its particular experience and expertise to:*

- *Work with the international community on ways of organising healthcare knowledge and making it accessible to practitioners and the public*
- *Assist with international efforts to create ways of identifying and sharing good practice*
- *Help countries develop knowledge systems that can make relevant knowledge accessible to their health workers and public.*

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## **The future**

*Global Health Partnerships* sets out ways in which UK experience and expertise in health can contribute practically and strategically to health in developing countries, as part of a much wider development programme. I have also suggested some of the things that need to be done to ensure that progress is made.

The pace of improvement will depend on many factors outside health – not least, trade and investment, peace and security. Health too has an important role to play in the creation of prosperous and healthy societies.

At the start of this summary I emphasised the differences between the UK and developing countries and the differences between developing countries themselves. These are profound. However, we must also recognise the connections.

We share three important themes that between them characterise health policy in the 21st century and will help determine whether any of us can afford the standards of health and healthcare we desire:

- The UK and developing countries alike are concerned with public health, health promotion and education – with early health, not late disease – and are only beginning to learn how best to achieve improvements in these areas
- We are alike too in the emphasis on the development of knowledge, evidence and standards – codifying much more of clinical practice – and both the challenge and the support this brings to professionalism
- We also share the recognition that public participation in decision making and personal patient involvement in our own care are essential in ensuring that we have high-quality services and a healthy population.

We may all also, in the future, measure the effectiveness and affordability of our health systems by the attention given to:

- Early health, not late disease (perhaps using the early health index being developed by the Pacific Health Summit)
- The practical application of knowledge
- The participation of our citizens.

We also increasingly share in the threats and challenges of global health – and global disease – and with our increasingly diverse population need to understand the diseases, genetic predispositions and cultures of, for example, Sub-Saharan Africa and South Asia if we are to look after our own population well.

There are things we can learn from each other in all of these areas. There are partnerships we can create and strengthen between countries and between communities and individuals. Over time we can perhaps start to emphasise more the similarities between us, rather than the differences – and even stop using the words ‘developing’ and ‘developed’.

Creating true global health partnerships will both help to improve health and, by bringing people together, contribute towards improved relationships across the world and stand the UK in good stead in a changing and risky world.

Finally, in the words of *Our Common Interest*, the report of the Commission for Africa, “*What we are suggesting is a new kind of development, based on **mutual respect and solidarity**, and rooted in a sound **analysis of what actually works**”.*<sup>7</sup>

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