Global Health Partnerships

The UK contribution to health in developing countries

Nigel Crisp

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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.

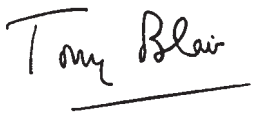
There is no doubt that to meet the health Millennium Development Goals – on reducing maternal and child deaths, and combating AIDS, tuberculosis and malaria – there is a need for a strong health workforce globally. The G8 has promised to help developing countries to fund health care for all. The challenge 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.



Tony Blair, Prime Minister
February 2007

Acknowledgements

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.

See page 175 for further acknowledgements.

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1

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.

The main findings

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[1]

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

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.

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.

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

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.[2]

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.

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.

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".*

Many 'developing countries' are growing fast economically and becoming important 'emerging markets'.

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.

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:

- 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[3] 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[4] 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.

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

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.

… 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.

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.

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.

… 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.

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.

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.

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.

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.*

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.

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.

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.

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.*

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.

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.*

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.

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.*

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.

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.*

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.

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.*

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[5] 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.

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.

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.[6]

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.

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.*

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.*

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.

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.*

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.

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.

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.*

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****"*.[7]

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2

What People Told Me

Summary

This chapter:

- Describes what people said they would like to see come from working collaboratively with the UK and the priority areas that they have identified
- Emphasises their need for strengthening the whole way that health systems and institutions work from the supply of drugs to the management of hospitals
- Highlights the crisis in staffing experienced by developing countries and the role that the UK could play, and the responsibility it has to do so
- Sets the scene for a more detailed look at health needs and development policy in the next chapters.

"Send us some nurse trainers", *"Help us to develop our medical school with adjunct faculty from the UK who can come for periods to teach on specialist subjects"*, *"We need leadership and management training"* and *"The biggest issue is training and supporting the local workers"*.

These are just a few of the things said to me as I prepared *Global Health Partnerships*.

I have been privileged to visit several African countries, as well as India, during the research for this report, and to meet with some 15 health ministers – from Africa, India, Pakistan, China and the Caribbean – in their home countries or at regional and international meetings.

These visits have allowed me to see a range of health facilities – to see both the innovations and the challenges in rural and urban settings – and to meet and listen to front-line staff and patients as well as researchers, staff associations and people working with non-governmental organisations (NGOs), private businesses and UK and other development agencies.

... all the countries ... had clear visions of what they want to achieve and, often, ambitious plans.

I have also had the opportunity to meet with leaders in international agencies, including the World Health Organization and the World Bank, people working in health services, education and industry, both internationally and within the UK and those involved in supporting and promoting voluntary and community activity. I have also hosted meetings of stakeholders in the UK – some with representatives of migrants from developing countries to the UK.

What people told me

Each country is unique and different from its neighbours. This is reflected in different policies and emphases in their health policy, with some giving more attention to the wider determinants of health, the environment and education and others more interested in intervention and services.

There are differences between countries, but also big regional differences, with India and China, for example, growing rapidly. They are faced with the problem of the many left behind in poverty in their rapidly modernising societies and growing inequalities. They are clearly in a different position from the countries that need to grapple constantly with very low national incomes and little hope of significant growth. Indeed, India and China now provide aid and assistance to many developing countries.

In all the countries I visited, however, I met ministers and government officials who had clear visions of what they want to achieve and, often, ambitious plans such as the Indian Government's National Rural Health Mission – designed, as its name implies, to raise the whole standard of health in vast rural India – and the Ghanaian Government's health policy, which aims to create more cross-sector collaboration to tackle public health.

There were also common themes in my discussions with individual countries and with those in representative roles such as the Mozambique minister of health, president of the World Health Assembly 2006; the Botswana minister, chair of the African Union Ministers of Health; and the World Health Organization regional director for Africa.

All are facing very difficult circumstances. There is a common health context – well understood from many reports – of dreadful disease, extremely high levels of maternal and child death, poor health, inadequate funding and other resources, critical shortage of health workers and weak or non-existent health systems.

These problems are compounded by poverty and environmental problems such as lack of clean water and safe disposal of waste. They are made worse still in some countries by very difficult political and social circumstances, corruption and weak institutions and civil society.

There are also difficulties, which were on occasion expressed very forcefully to me, in the relationships with the developed world and with providers of aid. Local leaders need to be supported not undermined – ultimately, *"Africans will solve Africa's problems"*. Migration to developed countries has helped weaken health services; some of the aid programmes dealing with particular diseases have inadvertently damaged wider health services; there is resentment of uncoordinated aid and the burdens it brings, and anger at some high-handed 'northern' behaviour and assumptions.

Against this general background, the UK's international leadership on aid and development is very well recognised. Additionally, its contribution to general 'budget support' and to specific disease programmes – countering AIDS, malaria and tuberculosis – is very warmly welcomed. I have also found a real desire for greater links and partnerships with the UK – sometimes built on shared history and traditions.

They want – and need – more funding for health, but they also want to draw on UK experience and expertise in health and work together in a spirit of mutual respect.

They want – and need – more funding for health, but they also want to draw on UK experience and expertise in health and work together in a spirit of mutual respect around three main areas:

- Strengthening public health, health systems and institutions – covering all aspects of public health and services, their operational management and delivery
- Providing education and training for health workers – and retaining the ones they have
- Making evidence and best practice – derived from high-quality research – available to health workers, policy makers and the public alike.

It was generally governments, leaders of organisations and official bodies who articulated the needs in this very structured and managerial way, However, I and my colleagues also met many health workers, some local voluntary organisations and – in West Bengal – a locally elected block management committee.

What they told us provided vivid illustrations of all these points – with examples of medicines bought but not arriving where they are needed, difficulties in repairs of equipment, shortage of staff, poor staff living conditions and a general lack of knowledge of the best methods of health promotion and treatment.

They were also very clear that they would welcome people from the UK to work alongside them in any capacity. Clinicians would also welcome more contact with UK clinicians and, in many cases, the chance to study or work abroad. It was interesting to note just how respected UK qualifications and knowledge are. This is reflected in the fact that India still relies, for example, on the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners for accreditation.

UK experience and expertise

Many countries are reforming their health systems and are interested in learning from and sharing experiences with the UK in areas such as quality, planning, strategy, regulation, human resources and the development and use of information and statistics. We had discussions about this in both India and Africa.

This interest explicitly recognises the importance of tackling all the determinants of ill health – including water and education – and not just concentrating on health services. It is concerned with developing public health and with methods for promoting health and introducing both better surveillance and greater involvement of the community. It is also explicitly concerned with developing primary care and 'close to client' services.

Developing countries are looking for support from people with direct and, preferably, current experience.

They also expressed particular needs around management and organisation. This is partly about the management of organisations and services but it is also about distribution and logistics – the management of the whole way in which drugs, for example, are bought, distributed and accounted for – about maintenance and the supply of equipment and about communications and infrastructure.

These were the most pressing issues for several of the ministers we met, who were facing daily problems of medicines that had been purchased but that were not reaching local clinics, of equipment not being maintained or serviced and of staff not looked after and managed.

What is very apparent is that in these areas developing countries are looking for support from people with direct and, preferably, current operational experience. They would like to see secondments or links with the people in the UK who are dealing with a particular issue – be it medicines management, patient safety, infection control or staff retention – in their own countries.

This clearly fits in very well with the long and powerful tradition of partnerships between UK institutions and those in the developing world through which hospitals, for example, exchange staff and provide training and equipment for hospitals in developing countries. These links are seen by the UK institutions and individuals involved as being two way, with scope for learning and personal development.

However, the biggest issue raised with me has been the need to scale up training and education for all types of health staff. Many countries have their own plans and action under way. The Ethiopian minister of health, for example, has focused on this issue as part of wider action to develop the health system and has scaled up the training of local community health workers ten fold in a single year.

Lack of funding to pay for more staff means that some countries actually have large numbers of health workers unemployed or working in different occupations.

As many people reminded me, the UK has benefited from the immigration of many health workers from developing countries in recent years – and has had a workforce drawn from across the globe ever since the creation of the NHS in 1948. I believe, as I will argue later, that the UK should see itself as having a responsibility because of this immigration – and because it is a global employer – to contribute to solving the staffing crisis in developing countries.

I have also been told that the recent decision to restrict health worker migration to the UK, while welcome in stemming emigration, has damaged long-established training links and is diminishing the UK's position as a leader in health education.

A great deal of focus in the developing world is on meeting the needs of rural people – providing good health advice and supporting remote and rural health workers. Indeed several people have told me that the single biggest issue is how to both support and motivate the isolated doctor in charge of a hospital – often called the district medical officer.

There is experimentation around the use of mobile phone technology, satellites and advances in low-cost computing. Many governments are investing in infrastructure and the big ICT companies are developing their plans to do more business in low and middle income countries. Here again there was a great deal of interest in working with UK organisations to address these issues.

Outside government

There was considerable overlap between the views of government and the other people we met. However, in making recommendations I want to consider both how to respond to the 'official' views and to those of individuals and groups, who necessarily have a different perspective. In the UK too – in a parallel way – there is room for government and official action and for local, voluntary and independent responses to the health needs of developing countries.

This cannot all be about government to government and official to official planning – and indeed a great deal of improvement has been made through the spontaneity, creativity and energy of passionate individuals. The question is really how to get the best from the huge resources, professionalism and impact of the one and the sometimes ground-breaking initiatives and person to person contact of the other.

We also talked with several international agencies, NGOs and education and research bodies and received confirmation that these three areas identified were indeed fundamentally important. There was a general welcome for greater involvement from health professionals and health services, but strong advice given about the need for making sure people were well prepared and that the whole approach should be 'demand led' from the developing countries and not 'supply led' from the UK.

The voices of the poor

The Voices of the Poor study, undertaken in preparation for the World Development Report 2000/2001 *Attacking Poverty*, researched the experiences of more than 60,000 poor men and women to try to understand poverty from the perspective of the poor. It included some quotations:[1, 2]

"Nobody hears the poor. It is the rich who are being heard." – a discussion group of poor men and women, Egypt

"Poverty is humiliation, the sense of being dependent and of being forced to accept rudeness, insults, and indifference when we seek help." – a poor woman, Latvia

"When the poor and rich compete for services, the rich will always get priority." – a discussion group of poor men and women, Kenya

African leaders

Leaders from developing countries are very clear about their needs. These African leaders speak for many.

Firstly, as Bience Gawanas, the Commissioner of Social Affairs for the Africa Union Commission, has written about how all parties need to work around a common agenda:

"The African Union believes that the key to successful healthcare delivery in the continent is the development of sustainable health systems that are equitable and based on strategies and principals of primary healthcare. This requires effective use of exiting knowledge, technologies and innovations along with appropriate structures and strategies to apply them.

Success, however, is contingent on strategic management, improving the attitude and skills of health workers, new forms of cooperation between international health agencies, national leaders, health workers and communities, and other relevant sectors of civil society".[3]

Secondly, as Chinua Akukwe illustrates, there are real tensions and problems arising from the involvement of so many parties:

"Healthcare financing in Africa whether clinical care or public health, depends heavily on financial assistance from bilateral and multilateral agencies, international philanthropies and non-governmental organisations.

This has led to a situation where there is very little coordination of externally funded services and lingering concerns over the national supremacy of national health policies and national priorities.

This creates a situation whereby ministries of health in Africa spend a lot of time responding to donor inquiries and concerns, and less time coordinating provision of services. In addition, the constant diplomatic and technical tug-of-war between external donors and host governments over governance and accountability issues creates unanticipated problems of uncertainties regarding stable funding and sustainability of programmes beyond external funding cycles.

The fate of target communities often hangs in the balance while disagreements over funding mechanisms and management linger between national governments and external donors".[4]

"The fate of target communities often hangs in the balance while disagreements over funding mechanisms and management linger between national governments and external donors."

Chinua Akukwe

What is needed

Dr Luis Sambo, the World Health Organization regional director for Africa, set out his prescription for what was needed from the UK as follows:

Building capacity on strengthening health system:

- *Regional level: provide experts on organisation and management of hospitals*
- *Country level: provide financial resources to countries to support district health systems to scale up priority interventions through primary health care.*

Development of human resources for health technical and expert support is needed for:

- *Human resources planning policy development in countries*
- *Scaling up and sustaining training through evaluation and revision of medical school, health sciences and nursing training programmes, revision of curricula-strengthening teacher capacity and infrastructure and equipment of training institutions*

- *Supporting effective utilisation of health workers in countries, through advocacy for direct investment in incentive packages (motivation and retention)*
- *Financial resources for scaling-up training of health workers in countries*
- *Strengthening regional training institutions for institutionalising and conducting key postgraduate training courses.*

Support to the World Health Organization inter-country technical support teams:

- *Provide experts on health systems for policy development, strategic planning and health service management*
- *Secondment of experts in development of human resources for health.*

Knowledge management:

- *UK to join partnerships between the African Union, the New Partnership for Africa's Development (NEPAD) and European Union, and other donor countries in telemedicine and E-health*
- *Support for the establishment of the Health Systems Observatory, including the African Human Resource for Health Observatory*
- *Support for health systems research, particularly assessment and analysis of current status of national health research systems in Africa, in preparation for 2008 Summit on Research in Health.*

Conclusions

This chapter has described what people told us about how the UK could work – collaboratively and with mutual respect – to help support their efforts to improve the health of their populations. It has also started to sketch out the opportunities to draw on UK experience and expertise.

The next chapters put this in context of the health of the populations, of development policy and, finally, of the capabilities of the UK health system.

This chapter finishes, however, with verbatim quotations from an interview recorded by Jo Anne Bennett with a long-serving doctor in a rural part of Africa. It sets the scene well for the more detailed look at health needs in the next chapter.

"Well, in so far as health delivery in the north is concerned there are two major issues. Both the public health and the curative problems are quite difficult. The clinical aspects of pathologies are quite difficult. The disease burden here is the real problem. We have problems in both directions – that is, public health and clinical institutions. And that is why we have the highest maternal mortality in the country – in the country and, I think, even in the whole north.

The basic problems we have are staffing problems, one of our major problems. That, and the maintenance of the health institutions that are in place. Access to quality healthcare is a very big problem. The reason being that the people here are so poor that they are unable to afford care. The people are also ignorant about their own health and for that reason they sometimes don't know what they need. And the few health staff that are present are unable to cope with the burden of the work.

Logistics is another very serious problem – that is, equipment. The equipment is just not here. So we have this problem of people chasing after equipment. And sometimes, too, equipment chases people. Sometimes you have the equipment and it is sitting there and not being used because there is nobody qualified (to operate it). So at times the equipment becomes obsolete (without ever being used). And other times you have qualified people in health institutions who don't have the equipment they need. So the health personnel get frustrated and want to leave.

So we have to look at three things:

We look at the public health sector, the education in the public health sector to see if that can be done. (We need to) sensitise people to what they should do to strengthen their own health.

Then, we should strengthen our curative health institutions, the clinical care institutions, in terms of modern equipment and qualified staff – lab technicians, assistants etc.

Then, logistics – in terms of medical consumables, such as drugs etc. Once people have the money and the prescription and the drugs are there ..."

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3

Health and Health Services in Developing Countries

Summary

This chapter:

- Describes how early death, disease and disability are shockingly common in developing countries – much of this is linked to a few clear causes
- Shows how health, clean water, sanitation, the environment, education and poverty affect each other – and need to be tackled jointly with a coherent approach
- Recognises that cultural issues are crucial. Whereas there are inspiring examples of how communities have worked together to improve their health, there are even more examples of powerlessness, neglect and poor governance
- Emphasises that developing countries need systems centred on primary care and public health as well as better links between these and vertical disease programmes and hospital services – they also need much more funding, staffing and equipment
- Concludes that there are some clear ways in which UK experience and expertise could contribute – alongside extra funding – but only through working and learning together, not by applying UK ready-made solutions to developing country problems.

HIV, malaria and TB are among the leading causes of death in Sub-Saharan Africa … These deaths occur despite the relatively small cost required to prevent or treat these diseases.

Inevitably, in talking about health, this chapter – and the report generally – will talk about all the problems and difficulties that people face. This should be seen in the context of the enormous passion, energy and commitment that is going in to solving these problems – and the considerable progress in improving health in most countries in the world. There are very many success stories.

There are, however, far too many truly shocking statistics about health, illness and death in developing countries. The following table provides a glimpse into the situation.

Table 1: Health comparisons between Sub-Saharan Africa and the UK

Life expectancy at birth for a woman	
In Sub-Saharan Africa	In the UK
46 years	**78 years**
Deaths in child birth	
In Kenya	In the UK
1,000 in 100,000	**13 in 100,000**
Child deaths before 5 years old	
In Sub-Saharan Africa	In the UK
179 in 1,000	**6 in 1,000**
People living with HIV/AIDS	
In Sub-Saharan Africa	In the UK
7.3% aged 15 to 49	**0.1% aged 15 to 49**
Annual expenditure per person on health ($)*	
In Sub-Saharan Africa	In the UK
$36	**$2,508**

Source: see References 1, 2, 3, 4
*Total average health expenditure includes all expenditure, including public and private expenditure.

A little further analysis of this stark table reveals the main health issues facing developing countries and underscores why the emphasis in world health programmes must be on HIV/AIDS, malaria, tuberculosis, child and maternal health, as well as the emerging non-communicable diseases.

- HIV, malaria and tuberculosis are among the leading causes of death in Sub-Saharan Africa. More than five million deaths occur globally each year, the majority of them in the developing world. These deaths occur despite the relatively small cost (between $0.05 and $10 per case) required to prevent or treat these diseases.[5]
- The deaths in childbirth are associated with the mother's health and care during pregnancy, unhealthy conditions around birth and lack of knowledge of safe care practices for the newborn.
- The main killers of young children are diarrhoea, malaria and acute respiratory infections[6] – again quite different and more easily preventable and treatable than in the UK – where deaths are due to congenital and chromosomal abnormalities, neoplasms and nervous system diseases.[7]

- It is the poor in poor countries who spend the highest proportion of their income on health services.[8]
- Today, the burden of deaths and disability in developing countries other than Sub-Saharan Africa caused by non-communicable diseases, particularly cardiovascular conditions, outweighs that imposed by long-standing communicable diseases.[9]

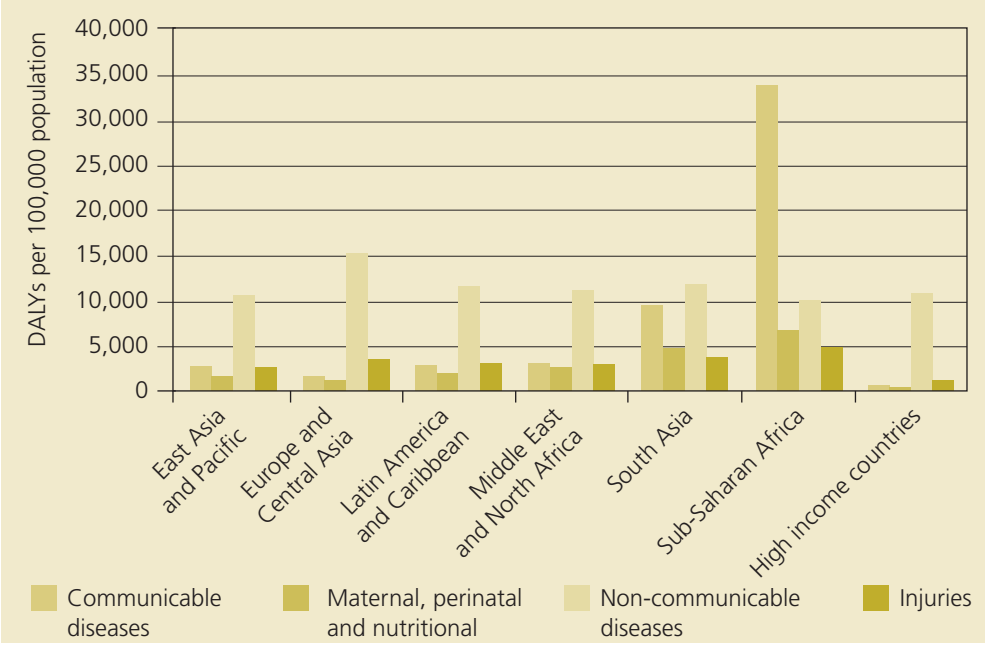
These shocking facts mask a great deal of variation between countries but also reveal something of the depth of the problems. Whereas almost all of these examples come from Sub-Saharan Africa, there are comparable difficulties in other parts of the world – in India, for example, 1 in 185 births results in the death of the mother, in Bangladesh 1 in 7 children die before the age of 5.[10] A quarter of all maternal and neonatal deaths globally occur in India.[11]

There are some bright spots within this bleak picture. The poorest countries have reduced child mortality by half in the last 25 years. Smallpox was eradicated in 1977. Polio could be eradicated within the next few years. The poorest countries have also cut dramatically the incidence of a number of communicable diseases such as measles, guinea worm and leprosy.

The burden of disease and disability

One way of fully understanding the impact of illness – or the burden of disease – is through making a calculation of 'disability adjusted life years' (DALY) as shown in the following figure.

Figure 1: Burden of disease in 'disability adjusted life years'[12] per 100,000 population due to broad disease categories by region, data for 2002



Source: see References 13 and 14

This chart demonstrates the enormously large burden of disease in Sub-Saharan Africa in particular, but also shows differences in causes of disability and illness between developed and developing countries. Whereas communicable diseases dominate Sub-Saharan Africa, non-communicable diseases represent a substantial and growing burden, and the leading cause of death in all other regions is cardiovascular disease.[14] The World Health Organization (WHO) has drawn attention to the double jeopardy that the developing world is experiencing, with epidemics of both communicable and non-communicable disease.[15]

As developing countries become wealthier and adopt the habits of the developed countries, they will see a further rise in incidence of non-communicable diseases such as diabetes, cardiovascular disease and cancer. We know that some populations are particularly susceptible to some conditions and can already see in the UK, for example, that people of South Asian origin are six times more likely to have diabetes than the majority population.[16]

Projections suggest that by 2030 there will be 79 million people in India with diabetes compared with 30 million in the USA.[17] There is growing awareness of these new epidemics and the Oxford Health Alliance, for example, is already working on how to confront the epidemic of chronic disease in developed and developing countries alike.[18]

In countries with weak health infrastructures, diabetes is anything but the manageable condition it can be in the rich world.

Michael Birt of the Pacific Health Summit writes: *"Diabetes – a disease usually associated with affluent societies – is particularly dangerous. In countries with weak health infrastructures, it is anything but the manageable condition it can be in the rich world. A person in Mozambique who requires insulin injections, for example, will probably live no more than a year. In Mali, the average lifespan after onset is 30 months."*[19]

The problems presented here are not just about death and suffering but also about the burden of disability and illness and the impact of disease on livelihoods and the economy of a whole nation. At the macro level, the United Nations has estimated that economic growth is 1% lower for every 10% of HIV prevalence.[20] For the individual, the disability or illness of one member of a family can have devastating effects for all the others.

The Global Burden of Disease and Risk Factors study found that the 'dependency ratio' (the ratio of dependent people to the population of working age) is about 10% in Sub-Saharan Africa compared with 7–8% elsewhere.[6] Against this background, Professor Ken Andrews of the Royal Hospital for Neuro-disability provided a thorough analysis for this report of the need for rehabilitation in general – and the role that non-governmental organisations play in this in particular – to be seen as central to any health strategy in Sub-Saharan Africa.

Figure 1 also clearly demonstrates the impact of injuries in developing countries – the dangers in the environment, the lack of health and safety protections and the risks of violence. More than 800,000 people died in Sub-Saharan Africa in 2001 from injuries, 8% of all deaths. Some 500,000 of these deaths were accidental –

with 200,000 the result of road accidents – and others from poisonings, falls, fires, drowning and other causes. The remaining 300,000 deaths were the result of violence, self-inflicted injuries and war.[6]

The scale and range of these injuries brings out once again the relationship between health and society more generally. Irwin Waller, a leading criminologist, has stressed the importance of tackling public health as an integral part of creating a healthy society.[21]

In this context, mental health is another important health issue, and is linked particularly to conflict and poverty. However, it is often a neglected or stigmatised issue in developing countries.[9]

Health in the wider environment – causes and effects

This brief discussion has already begun to illustrate the links between health and the wider environment – where education can affect, for example, health and health can affect education.

… children of mothers who have five years of education are 40% more likely to live beyond the age of five.

The following examples illustrate some of these links:

- Poor general education – good education and good health are mutually reinforcing. For example, in Africa children of mothers who have five years of education are 40% more likely to live beyond the age of five[22]
- Poor health education – health education, such as the need for breastfeeding, good nutrition and the need to wash hands, is particularly valuable when given from an early age
- Lack of access to safe water and basic sanitation – safe water is a prerequisite of good health. Safe water – alongside good sanitation and hygiene education – is needed to prevent diarrhoea, still a major cause of child death. Some 1.1 billion people do not have access to safe drinking water and 2.6 billion people live without basic sanitation[23]
- Lack of food and adequate shelter – both are also prerequisites of good health. But more than 800 million people worldwide do not have enough food.[24] And 640 million children in developing countries live without adequate shelter[25]
- Conflict – an estimated 191 million people lost their lives directly or indirectly in the 25 largest instances of collective violence in the 20th century[26]
- Climate change – it is likely to cause rising sea levels, droughts, heatwaves, floods, crop failure and forced migration, all of which will affect the poorest and most vulnerable people most.[27]

Public health and primary care

A different model of care emerged ... controlled by communities themselves ... in a spirit of self-reliance and self-determination.

The importance of these issues highlights the necessity to take the widest possible approach to public health – one that addresses the whole environment as well as the more purely clinical aspects. Moreover, as Paul Johnstone and Isobel McConnan argue, there are sound economic arguments for focusing on public health:

"In the 1950s and '60s many developing countries faced a daunting task. Economic recession meant that many could not even start to emulate the West's medical model of health based on hospital medicine and high technology. A different model of care emerged, which recognised that the health of populations was determined by factors other than medical care and that these factors could be controlled by communities themselves, through collaboration with other sectors, such as agriculture, water sanitation, and education, in a spirit of self-reliance and self-determination." [28]

There are also sound economic and practical reasons for focusing on primary care – tackling health upstream, in the community, in the round, where people live.

The Alma-Ata Declaration of 1978 definition of primary healthcare included education about health, adequate nutrition, adequate safe water and sanitation, maternal and child healthcare, family planning, immunisation against major infectious diseases, prevention and control of local diseases, treatment of common diseases and injuries, and provision of essential drugs.[29]

Alma-Ata proved a turning point. It resulted in a new emphasis on public health and primary care throughout developing countries. It helped move investment away from hospitals and led to the building of networks of local health services with an emphasis on prevention – immunisation and education, for example – and on 'close to client' health services.

Inevitably, there were difficulties too – even where developing countries accepted the model in principle, some maintained a very hospital-focused model in practice – and in other cases thousands of local primary care workers, 'barefoot doctors and nurses' were given some training and then left to their own devices, with the result that their knowledge decayed and sometimes did more harm than good.

A significant part of the problem here was that secondary systems of care were frequently not adequately in place to support primary services, and that when they were in place they performed primary care in a secondary setting. This whole experience illustrates the need to have a well-balanced health system with the parts working in collaboration.

One of the most impressive examples of community action for public health is BRAC in Bangladesh:

Bangladesh's BRAC, a community-based group credit programme, has an 'essential health component'. This focuses on the poorest communities to ensure financial subsidies for healthcare and promote healthier behaviours and access to health services. It works with the village organisations (micro-credit groups) to achieve this. It has succeeded in increasing access to health services; use of sanitation and safe water; use of modern contraception; use of latrines; use of tube wells for drinking water; immunisation of infants; immunisation against maternal tetanus; vitamin A supplementation among children age one to five years; and postnatal care.

Outside agencies can also play their part with the BBC having a proud record:

The BBC World Service Trust funds a range of innovative development communication programmes and monitors performance of these programmes. It recently established strong results for a Cambodia maternal and child health media project. For example, there has been a measurable improvement in awareness of diarrhoea, a major killer of under fives, and:

- *The practice of washing hands to avoid diarrhoea increased from 10% to 25%*
- *The prevalence of diarrhoea decreased by 22% among respondents reporting incidences of diarrhoea for children in their care.*

The powerlessness of the poor

These two examples are of situations where local people have been enabled to take some action for themselves, and where policy supports effective action. Too often, not only do the poor have inadequate health services, but they also suffer from a lack of power to alter their situation.

The Voices of the Poor study, undertaken in preparation for the World Development Report 2000/2001 *Attacking Poverty*, researched the experiences of more than 60,000 poor men and women to try to understand poverty from the perspective of the poor. Powerlessness was a major theme that emerged.

A book published from the study[30] said, *"Poor people's lives are characterised by powerlessness and voicelessness, which limit their choices and define the quality of their interactions with employers, markets, the state, and even non-governmental organisations. Institutions both formal and informal mediate and limit poor people's access to opportunities ... Many poor people define poverty as the inability to exercise control over their lives."*

Health services

Health systems in developing countries typically involve tertiary, urban-based hospitals, smaller regional or district hospitals and a network of primary healthcare centres that coordinate rural sub-centres or health posts.[31]

Whereas urban facilities are staffed by doctors, primary healthcare centres may be staffed by nurses or a mid-level grade worker between a doctor and a nurse – in some cases a health worker trained to a lower or basic level.

Community outreach work is typically provided by community health workers, an auxiliary level below nurses, trained specifically to deliver basic, cost-effective services in simple rural facilities.

The broad structure of a health system, as described above, seems sensible – with scope to invest in community services and focus on local care and local intervention. However, there are three important features that make this problematic.

Firstly, as the World Health Report 2000 outlines, the quality of primary-level care has been doubtful in many countries; the lack of availability of drugs or skilled staff means people often chose to travel to the nearest hospital.[31]

Secondly, there is the question that needs to be resolved in each country as to how these health systems relate to traditional medicines and traditional healers. In some cases, there is a reasonable degree of integration, whereas in others the systems and practitioners themselves are in opposition.

Thirdly, and underpinning the others, developing countries spend little on their health systems and, even though their citizens spend more 'out of pocket', the overall expenditure on health is low.

National budgets are highly constrained – often the overall tax take is very low. But governments also allocate the limited resources elsewhere, frequently seeing investment in health as less attractive than investment in productive sectors.

Average publicly funded health spending as a proportion of national income is around 7% in high-income countries but just 1% to 3% in low-income countries. This means that many developing countries, in Sub-Saharan Africa and South Asia, are spending much less than the Commission on Macroeconomics and Health target of $34 per capita – the minimum it said was needed to deliver an essential package of care.[32]

In addition, almost all African governments are missing their own target of 15% of government budgets allocated to health, set by the Abuja Declaration of 2001.[33]

The following table sets out total average expenditure on health, and the relative levels of expenditure and the splits between public (government) spending and private (insurance and direct) spend.

Table 2: Global health expenditure

	Total % of GDP	Public: % of GDP	Public: % of total	Total per capita expenditure $
East Asia and Pacific (2003)	5.0	1.9	39.0	64
Europe and Central Asia (2003)	6.5	4.5	67.3	194
Latin America and Caribbean (2003)	6.8	3.3	48.2	222
Middle East and North Africa (2003)	5.6	2.7	50.9	92
South Asia (2003)	4.4	1.1	26.3	24
Sub-Saharan Africa (2003)	6.1	2.4	41.2	36
High income countries (2003)	11.2	6.7	63.9	3449
United Kingdom (2002)	7.8	6.7	83.0	2508

Source: see References 3 and 4

In Africa and South Asia, there is a wide range of total health expenditure, going down to $5–$10 in parts of Africa and India. For example, average total spend on health is $5 per person in Ethiopia and $13 in Malawi, compared with $295 per person in South Africa.

Most finance for healthcare in poor countries comes from the poor themselves – their 'out of pocket' spending. In India, 75% of health spending is through the private sector and 97% of this is financed out of pocket.[34] This out of pocket spending provides a major barrier to health service uptake, can push families into deep and intractable poverty, and cannot cover spending on relatively major treatments that need a risk-pooling approach.

The USA's health expenditure, by contrast, amounted to about 15% of Gross Domestic Produce in 2003, with private expenditure amounting to about 55% of the total, mostly paid for through insurance.[34]

Health facilities, constraints and access problems

As a result of the poor level of funding, there are serious constraints on health facilities. Access is a particular problem, especially for those who live in remote areas. The constraints are well documented and summarised in the *Global Burden of Disease and Risk Factors.*[6] This lists some of the key health system constraints as:

- Financial inaccessibility – inability to pay and informal fees
- Physical inaccessibility – distance to facility
- Inappropriately skilled staff at facilities
- Poorly motivated staff at facilities
- Weak planning and management
- Lack of inter-sectoral action and partnership
- Poor quality care among private sector providers
- Local cultural beliefs and preference for traditional providers.

These problems may be made more severe by resource limitations, but they derive from a much more complex set of issues.

Weaknesses in service delivery may result from problems at the front line, or may be caused by factors further back in the system. Ranson and others[35] analysed constraints by five different levels: community and household, health services delivery, health sector policy and strategic management, public policies cutting across sectors, and environmental and contextual characteristics. On the first of the five levels, the *Global Burden of Disease and Risk Factors*[6] comments:

"At the community and household level, lack of demand can limit coverage. This lack may stem from cultural factors, such as low acceptability of immunisation or prenatal care, but it may also result from financial and physical barriers to access. For example, estimates indicate that, in Niger, children under five average only 0.5 visits to a health provider per year, and in Bangladesh, only 8% of ill children were taken to a qualified provider."

The report makes clear that to fully address the constraints, problems at each of the five levels must be addressed.

Governance and management issues

Governance issues are clearly very important. The 2006 UK Government International Development White Paper[27] has highlighted the fact that only through improved governance – and better accountability, with less corruption – can sustainable long-term improvements be made and owned by the country itself.

Management of the limited resources available for healthcare can also be poor. It can be particularly difficult to attract good people into the hardest management jobs – those at district level. Moreover, as the *World Health Report 2006* outlines, there are few management or support staff in developing countries. This shortage of staff is compounded by a whole series of problems including:

... one in three people ... do not have regular and affordable access to essential drugs.

- There are major health workforce problems in most developing countries. Many low income countries have fewer than 1 health worker per 1,000 population – against a WHO advised minimum of 2.5 per 1,000. The *World Health Report 2006*[34] estimates there is a shortfall of around 4.3 million people in the global health workforce.
- Effective heath service provision also needs good physical facilities such as hospitals, clinics, stores and accommodation. Even if money is found for the initial capital costs, there is all too often a substantial shortfall in maintenance money available from the country's recurrent cost budget.
- These physical facilities also need sound and reliable services such as safe water, sanitation, energy, waste disposal, delivery access and communications. There are very often countrywide problems associated with the provision of a number of these services.
- A good health service must be able to supply the drugs people need. But the WHO estimates that one in three people in developing countries does not have regular and affordable access to essential drugs.[36] Not only are drug budgets inadequate, but drug procurement is often inefficient or corrupt and logistics and distribution flawed.
- In some cases, the introduction of 'vertical' programmes, focused on one disease – HIV/AIDS for example – has inadvertently damaged wider health systems by giving priority to one area. This is a common and current problem that requires a change in how these vertical programmes are planned and run so that they take account of the need to sustain good general – or 'horizontal' – health services for a population.
- Underlying all this is a lack of information – even basic data about disease and services – and the absence of any means of evaluation.

Conclusions

This brief survey has attempted to describe something of the reality of health problems and health provision in developing countries.

In thinking about how UK experience and expertise can contribute, three themes stand out:

- There is a shortage of resource – in all areas of staffing, money, facilities, equipment, drugs and information – although there are opportunities to use the available resources more effectively

- There have been many attempts to tackle these issues – and any support needs to be informed by evidence of what has worked and not worked in the past
- UK experience and expertise has much to offer – but not by applying our solutions to other peoples' problems – solutions will need to be worked out together in the circumstances and within the constraints of the developing country.

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4

Development and Aid

Summary

This chapter:

- Shows how the particular problems – of disease, education or employment – must be tackled in the context of the whole political, social and economic development of a country
- Describes the key features of international policy and activity in development, the need for increased coherence and coordination and the potential for some future instability
- Recognises that the UK is playing a leading role both intellectually in leading debate and through example in its own increases in funding and methods of deploying aid and that there is a high level of public support and interest in development
- Describes how health is central to development policy – both for its own sake and because there is clear evidence of the impact it can have in other areas, most notably the economy.

The starting point for most of us when thinking about international development and aid is probably horror, shock – and perhaps anger – at the levels of poverty, disease and misery in so many parts of the world.

The UK's own policy – now enshrined in the International Development Act of 2002 – is to have poverty elimination at the heart of all its work. All the activities of its development arm, the Department for International Development (DFID), are designed around this.

However, DFID's role in fighting poverty is not just to provide aid to the billion plus people – one in five of the world's population – who live in extreme poverty; but to offer support with **development** so that, over time, they are able themselves to control their destiny.

The way this is done is, of course, crucially important. Chapter 2 describes some of the problems of aid as seen by the recipients – too top down, too fragmented and too focused on limited and easily measurable goals. The brief analysis of development policies in this chapter describes how donors and recipients alike are trying to find the right mix of policies to address immediate issues – like AIDS – decisively, while working towards longer term goals of education, health improvement and economic and political stability.

Amartya Sen describes *"development as freedom"* in the book of that name.[1] He talks about the need to remove the various *"unfreedoms"* of poverty and disease that limit the choices that people have and describes how freedom itself – greater self-determination – is both *"the primary end and the principal means of development [p. xii]"*.

He also provides a useful analysis of the type of freedoms he believes are necessary. Together they provide a framework for most aspects of development policy:

- Political freedoms – including the development of civil society
- Economic freedoms – including infrastructure and access to capital
- Social opportunities – including education and health
- Transparency guarantees – building trust and countering corruption
- Protective security – safety nets for the most vulnerable.

"... the freedom to live lives – that they have reason to value"

Amartya Sen

All of these freedoms need, crucially, to be defined within the particular culture of the society. This reinforces the points made earlier about how people from developed countries need to approach development with some humility: bearing in mind that what works in, for example, the UK cannot simply translate to Africa – and deferring, wherever possible, to local leadership and local assessment of needs. Or, as Sen says, it is about *"... the freedom to live lives – that they have reason to value [p. 85]"*.

Development policy – in our interconnected world – cannot just be about developing countries. It is also about creating new relationships, understanding how we relate to each other both as countries and as individuals and about mutual self-interest.

Many of the difficulties that confront us – such as security, climate change and migration affect the whole planet. Others such as war and conflict, international crime, refugees, the trade in illegal drugs and the spread of diseases like HIV/AIDS can be caused or made worse by poverty in developing countries. Getting rid of poverty will make for a better world for everybody.

But, as the Commission for Africa said *"... there is something much deeper that motivates us. There is something greater, more noble and more demanding than just our shared needs and linked destinies. Our common interest, the title of our report, is defined by our common humanity"*.[2]

This is not, however, just about inspirational principles and ideas – although, these are very important. It is also, as the Commission was careful to describe, about hard-edged, tough-minded decisions and action – challenging each other – to find the best way forward on this *"a journey from charity to justice"*.[2]

... a journey from charity to justice.

The Commission for Africa

Development and health

This report is about the practical issues – what we can do in health, using UK experience and expertise, to help meet these needs. It is particularly about trying to understand what actually works and what will make a difference.

There is an obvious need for more evaluation and research – a recurring theme throughout this report. But there is also a clear need to locate health within the wider practice of development and to make sure that any interventions take account of – and draw support from – this wider effort. The brief survey of current development policy in this chapter attempts to meet this need.

Development in action

Development progress in any one social or economic sector tends to be closely linked to progress in other sectors. It is impossible, for example, to separate progress in people's health from progress in their education, their access to safe water and sanitation, their food and shelter, their freedom from conflict and so on. In turn, these factors depend on economic and governance progress.

The international development community now largely accepts that isolated development and aid interventions do not work well. They need to be set in a broader context of a country's development plan. In turn these plans need to be set in the context of a set of interrelated international efforts.

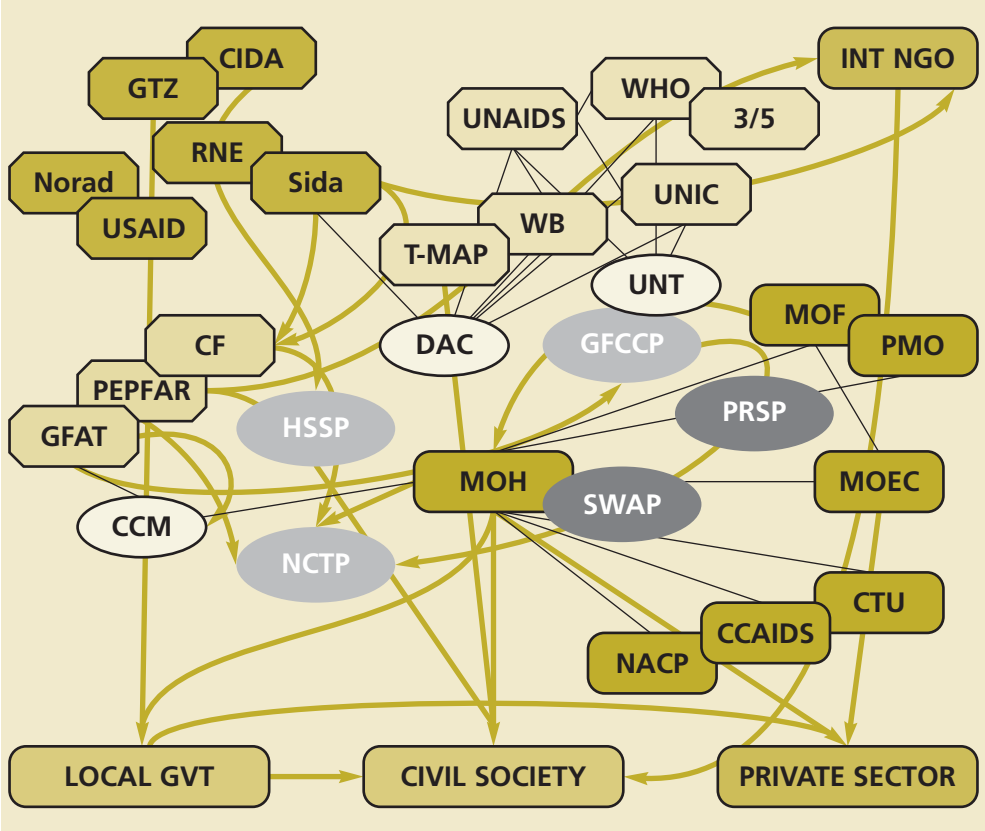
The various participants also need to be much more joined up. They include people from developing countries themselves; their governments, civil society organisations and local non-government organisations (NGOs); bilateral, mainly developed country, donors; international NGOs; international financial institutions such as the World Bank and the African Development Bank; sector-specific international bodies such as the World Health Organization; multilateral bodies such as the European Union; and more recently the large philanthropic organisations such as the Gates Foundation.

This complexity is matched by the complexity of the different ways in which development is managed and aid delivered. These include capital projects; technical cooperation projects; country sector-wide approaches (for example in health); international sector and vertical disease approaches (for example the Global Alliance for Vaccines and Immunisations, and the Global Fund to fight AIDS, tuberculosis and malaria); and country government budget support. Aid-financing mechanisms include grants, loans (with various degrees of subsidy) and debt relief.

All these forms of help may come with their own conditions, qualifications and methods of monitoring. The Government of Uganda had to deal with 684 different aid instruments and associated agreements between 2003/4 and 2006/7.[3]

Something of this complexity is captured in this diagram prepared by HLSP.

Figure 2: The Aid Effectiveness Challenge



Source: see Reference 4

Making sense of the complexity

Three recent initiatives have begun to bring coherence and focus to both the ends and the means of this complicated and often highly inefficient picture.

Firstly, in 2000, 189 countries signed up to the Millennium Development Goals. They re-committed themselves to the goals at the World Summit in 2005.

The Millennium Development Goals are a set of eight development targets that cover poverty and hunger, education, gender equality, health, the environment and a global partnership for development. They are unique in that they represent a consensus for development agreed by both developed and developing countries and that define poverty in more than just monetary terms.

Three of the goals relate directly to health – to reduce child mortality; to improve maternal health; and to combat HIV/AIDS, malaria and tuberculosis – but all are relevant to health interventions.

The Millennium Development Goals

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

African leaders committed themselves ... to lead their own development ... improving governance ... upholding the rule of law ... and using their resources to fight poverty.

Secondly, the Paris Declaration of 2005[5] tackled issues about:

- Ownership – that aid efforts should be set within country-owned national development strategies
- Alignment – that aid efforts should support country procurement and financial management systems, national development priorities, country capacity building, disbursement predictability, and untying aid from national suppliers
- Harmonisation – that aid efforts should use common arrangements for procedures and analysis
- Results orientation – that aid efforts should tie into results in the national and sector programmes

- Mutual accountability – that partner (recipient) countries should assess progress against the Paris Declaration targets.

Thirdly, developing and developed countries alike made a set of further commitments at Gleneagles in 2005, following the work of the Africa Commission.

African leaders committed themselves and their people to lead their own development by improving governance, upholding the rule of law and using their resources to fight poverty.

For their part, the G8 and the European Union (EU) promised to provide an additional $50 billion for development annually by 2010[6] and to improve the way that aid was spent, to cancel debt, to improve access to international markets, to help poor countries suffering from conflict or humanitarian emergencies, and to tackle international corruption and climate change.

These three developments have begun to create a great deal more focus on both the ends and means of development policy. However, there is much more to do. There are discussions under way about the future roles of many of the international institutions – the United Nations (UN), the World Health Organization and the World Bank – and the whole structure of the so-called 'aid architecture'.

At the same time new players, most notably China and India, are becoming much more active in aid and development. Their actions – and their growing international influence – may begin to challenge some of the current consensus around development and re-shape some relationships.

In November 2006, China hosted a summit for 41 African heads of state, which set the seal on several years of huge increases in Chinese trade with, and investment in, Africa. It signalled the importance that China attaches to its overall relationship with Africa.

In this context, it is worth noting that Chinese annual investment in Africa now amounts to more than all the aid received each year. This investment is helping shape local economies and therefore affecting the development of countries profoundly.

UK policy

The UK Government has played a leading role internationally ... in policy ... and in advocating ... greater levels of aid.

The UK Government has played a leading role in creating policy for development internationally and in advocating the need for greater levels of aid. Its success is reflected in a whole range of ways including the new initiatives on financing, the provision of AIDS drugs and the Gleneagles agreement.

This commitment led to the creation of the DFID – established in 1997 as a Department of State in its own right and with its own Cabinet Minister. Since then the Government has increased British aid by 140% in real terms and pledged to meet the UN-endorsed 0.7% of gross national income (GNI) target by 2013.

DFID has developed a new policy framework over the last nine years – based on the commitment to tackle poverty contained in the International Development Act of 2002 – and published three White Papers. The latest, *Eliminating World Poverty – Making Governance Work for the Poor,* was published in 2006. It focuses on five main areas: delivering on the promises made in 2005 at Gleneagles and elsewhere; helping to build states that work for the poor; helping people to have security, incomes and public services; working internationally to tackle climate change; and creating an international system fit for the 21st century.[6]

Over this period UK policy has moved away from individual projects and technical assistance to a more strategic approach with the emphasis on building up a country's own capacity. It has also played a leading role internationally in pressing for more joined-up donor approaches linked to this 'country-led' approach. This has included:

- Sector-wide approaches – which replace individual projects and donor efforts within a sector such as health with multi-donor support for an agreed approach to the whole sector. This often includes substantial reform and the agreement of health targets by donors and the country government
- Poverty reduction strategies – which are countrywide plans that cover all key sectors in the country as well as macroeconomic targets
- General budget support – unearmarked funding direct to the government, given to support the strategy.

DFID's new health strategy follows an extensive public consultation exercise. The strategy aims to review the health challenges facing developing countries, and sets out principles and priorities to guide future UK efforts in improving the health of the poor.[7]

The Scottish Executive

In March 2005 Scotland launched its International Development Policy[8] to complement the wider UK work led by DFID. This policy has three main strands:

- *Support for developing countries, especially through strengthening the capacity of NGOs in Scotland to engage in a two-way exchange of knowledge and expertise between Scotland and developing countries*
- *Assistance during times of international crisis*
- *Active consideration of the positive impact of our policies on the developing world – raising the level of awareness of development issues within the Scottish population.*

Scotland has identified its geographic priorities as being Sub-Saharan Africa – with a particular emphasis on Malawi – and areas affected by the tsunami; as

well as the thematic priorities of health, education and civil society development. It also included the earthquake affected region of Pakistan for 2005/6.

Scotland has signed a national cooperation agreement with Malawi, building on historical connections and creating links between organisations and individuals. Specifically, *"Scotland is addressing Malawi's identified need to increase the numbers and the skill base of front-line health workers and support and health governance system workers through addressing skills and people transfer including mentorship and training."*

Wales

The First Minister launched the Welsh International Sustainable Development Framework on 4 October 2006.[9] The framework recommends that the public sector in Wales should be better supported to create more formal links with counterparts in developing countries that are Millennium Development Goal focused.

Welsh Assembly Government policy is that funding is available for links between health services in Wales and health services in Sub-Saharan Africa and elsewhere in the south of the world. In Wales, the partners could be NHS Wales organisations, along with the university schools that educate health professionals in Wales. Overseas partners could include health providers, universities, trainers, NGOs, international health organisations and governments.

The Welsh Assembly Government has committed itself to the delivery of the UN Millennium Development Goals, international targets on reducing global poverty by 2015, and has decided to focus its efforts on Sub-Saharan Africa. Every project should support one or more of the Millennium Development Goals.

As Rhodri Morgan, the First Minister for Wales, has said: *"We will, as far as possible, limit our activities to those countries in Sub-Saharan Africa where Wales has existing links. This approach will benefit the strong link built over the last 20 years with Lesotho and the many other smaller links with communities and institutions in areas such as Uganda, Ethiopia and Somaliland through the Welsh Somali community."*

Northern Ireland

NICARE is the international development service of the NHS in Northern Ireland. The unit was established in 1990 to undertake international contracts on behalf of the Northern Ireland Health and Personal Social Services. NICARE projects have covered the broad range of health and social care programmes in more than 50 settings worldwide. Some of these contracts have involved supplying practitioners

for the direct provision of care; in others health service personnel provide technical assistance, training and an exchange of professional know-how.

Following the 1998 Good Friday Agreement and the resultant provision of a devolved assembly for Northern Ireland, the various political parties have established an informal all-party group on international development. From this, a strategy for how the assembly should encourage and facilitate international development activity has been developed by the all-party group.

Parliamentary work

International development, including health, is an area of great parliamentary interest, with many all-party groups devoted to work in this area as well as a common select committee. These include, for example, the all-party parliamentary groups on overseas development, debt, aid and trade and population, development and reproductive health.

The scale of international aid

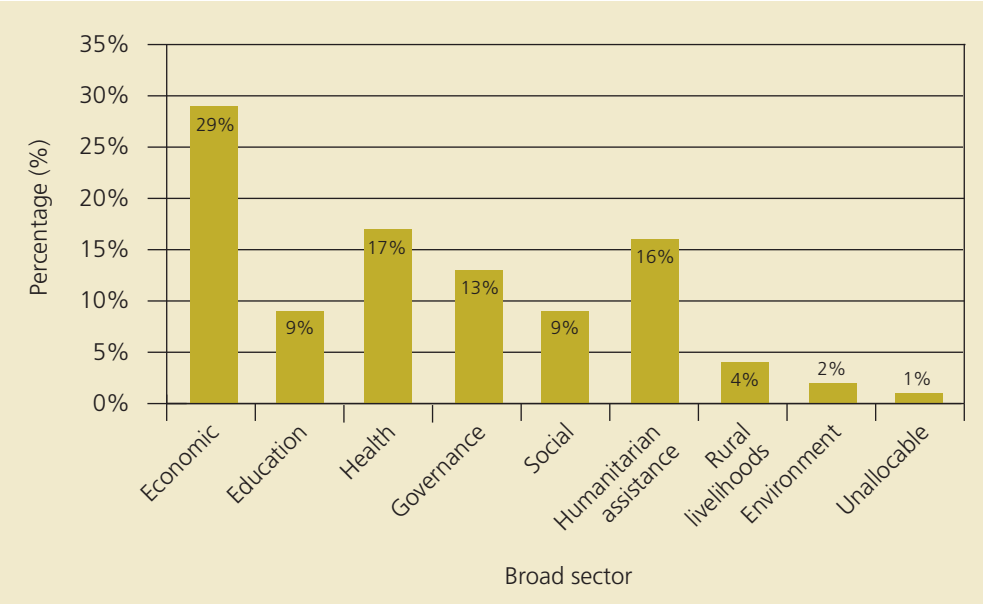
The amount of aid given by the developing countries has been rising rapidly in recent years. In 2001 the Organisation for Economic Cooperation and Development (OECD) development assistance committee group of countries gave £36.4 billion, or 0.22% of their GNI, in 'official development assistance'. By 2005, the equivalent figures were £58.6 and 0.33%.

The UK's spending has risen equally quickly. In 2001, it gave £3.2 billion or 0.32% of its GNI and in 2005 £5.9 billion or 0.47%. The total aid given to the 50 least developed countries represented around 12% of their GNI in 2003.

DFID spent around 17% of its bilateral programme on health in 2005/6.

Figures for health spending by all development assistance committee countries are not available but it is reasonable to assume that other development assistance committee donors also spend significant proportions of their programmes on health.

Figure 3: DFID bilateral aid by broad sector 2005/6



Source: see Reference 10

Even so, in spite of the substantial recent increases in aid, rich countries still spend less than half of the UN target of 0.7% of GNI.

The development and economic case for health

There are many reasons to prioritise health in development issues. It is a fundamental human right. Article 25 of the Universal Declaration of Human Rights states: *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family."* It is a fundamental human desire. The UN Millennium Poll of 2000, a global survey commissioned by Secretary General Kofi Annan, consistently ranked health as people's number one desire.[11]

This report has described the importance of development in other sectors, such as education, in order to make progress in health. But the dependencies work the other way too. For example, it is difficult to educate children who are regularly unhealthy, and unhealthy people will be less able to demand good government.

At the individual level, good health underpins the capacity for personal development and economic security. At a country level, the sound health of the population underpins poverty reduction, economic growth and national development. Health is also a consideration for the broader policy context in many of the Foreign and Commonwealth Office's strategic priorities, such as promoting sustainable development and poverty reduction; protection of the environment; as well as supporting economic growth and security.[12]

The 2001 Commission on Macroeconomics and Health set out the economic case very clearly. It said:

"The economic costs of avoidable disease, when taken together, are staggeringly high. Disease reduces annual incomes of society, the lifetime incomes of individuals, and prospects for economic growth. The losses are dozens of percent of GNP of the poorest countries each year, which translates into hundreds of billions of US dollars." [13]

... access to ... basic services would ... reduce child mortality ... maternal mortality ... and massively reduce the burden of communicable disease.

The Commission's report showed clear correlation between Gross Domestic Product (GDP) growth of countries and infant mortality rates (used as a proxy for overall disease conditions): the lower the mortality rate, the higher the GDP growth rate. The correlation applied for the poorest group of countries in the analysis, the richest group and the groups in between.

Against this background, the 2001 Commission on Macroeconomics and Health advocated scaling up health financing to the level of $34 per capita, which it calculated at that time allowed developing countries to provide a package of basic 'close to client' services.

It estimated that universal access to this package of basic services would, among other benefits, reduce child mortality by two-thirds, maternal mortality by three-quarters and massively reduce the burden of communicable disease.[13]

These arguments for investment in health are generally accepted internationally and have probably helped to generate more international funding for health. However, they have not yet served to influence public expenditure policy in many developing countries. Few, if any, developing countries are yet spending the level of funding from their own resources that would be needed – together with aid – to finance these basic services.

The dependencies between economics and health work both ways. As the latest Government White Paper says, *"Growth is the best way to reduce poverty."*[6]

Access to capital is a major constraint in health as it is in other sectors. Here, as elsewhere, the private sector can play a big role in investment, infrastructure development and providing services. Microcredit, too, has a developing role to play, both directly and indirectly, in health.

Different governments in developed and developing countries have taken different approaches to investment and to the use of the private sector. The UK has adopted a mix of policies that support direct government spending on public services, while promoting economic development and private sector investment in some areas. Some countries have emphasised more market-based economic reform, whereas others have taken a more planned approach.

Whatever the approach, health and the economy are interlinked and the issue of funding remains central to all debates about health and development. It is

critical as to whether or not countries will achieve the health Millennium Development Goals.

These obvious financial constraints require imagination and creativity in health delivery and in funding and investment – and proper evaluation of what works – to be brought to bear from developing and developed countries alike. Simply maintaining present approaches will not deliver the Millennium Development Goals.

UK public support for international development

International development became a very high-profile public issue in the UK in 2005 with the Gleneagles G8 Summit and the Commission for Africa report. The enormous public support – from the Make Poverty History campaign and the Live 8 concerts in nine countries – indicated the strength of feeling around the world about global poverty and the desire to do something about it.

Polls of the public in the UK show a continuing high level of interest in development issues and that children and young people in particular have a personal interest and may want to become involved in some way.

Surveys commissioned by DFID show that, among adults, nearly three-quarters (73%) of respondents were either very or fairly concerned about poverty in developing countries. Between 1999 and 2002, the proportion of respondents who said they were very concerned rose consistently from 17% to 29%, and in 2004 and 2005 has been stable at 26%.[14]

Among secondary school children, almost nine in ten (87%) say that they know something about developing countries. Around seven in ten (68%) of pupils are concerned about the basic living conditions of people in developing countries – lack of food, basic healthcare and education, with just under three in ten (28%) feeling very concerned.

Since 2004, there has been an eight-point increase in those who are very concerned, and an equivalent decrease in the proportion of those who are aware of the issues, but have no feelings either way. Younger children are significantly more likely to be concerned than older children.[15]

This level of interest is reflected in the experience of VSO. It is the largest independent volunteer-sending agency in the world and has more than 2,000 volunteers in service at any one time. In 2005/6, 1,311 long-term, 211 short-term and 226 youth volunteers (a new programme) left to work in 35 countries.

Some of this interest in global matters is also reflected among students. The gap year market is now worth more than £800 million, with more than 100 providers, many providing volunteering activities. There is no comprehensive national data on gap year participants; however, provider organisations estimate that each year up to 250,000 young people are now taking a gap year.[16]

The Year Out Group, a coalition of 35 organisations, reports that Africa is now the top destination for gap year travellers, with South Africa at the top, Tanzania second and Ghana also in the top ten. It concludes that the popularity of Africa among gap year students reflects a general trend across the travel sector – *"there has been a significant emergence of 'third world' volunteer-tourism programmes, which seek to combine tourism with the altruism of development work"*.[16]

Maintaining and deepening public interest in and support for international development is recognised by the Government to be a very important part of development policy. It has, for example, established a programme of partnering schools in the UK with schools in developing countries to build awareness.[6,17]

It will be even more important to sustain this support as the amount spent on development grows fast and new countries emerge as major donors and potentially start to change the way the international community operates.

Conclusions

This chapter has briefly described international policies for development as the background to this review of how UK experience and expertise in health can support health in developing countries.

A few major points stand out:

- The importance of understanding development in the round – and the interplay between the different areas – health, education and the economy – and between the many different players
- The pressing need for much better coordination among donors and for more effective aid processes and delivery
- The potential for greater instability and the breakdown of the current consensus as new countries become major donors
- The need for health interventions to be, as far as possible, country led and integrated into wider development programmes
- The constraints created by shortages of all kinds of resources mean that traditional solutions cannot easily be applied – and that a combination of rigorous implementation of what is known to work with creativity and invention about new solutions will be needed.

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5

The UK – National and International Health Policy

Summary

This chapter:

- Outlines the history of UK involvement in health in developing countries
- Describes the Department of Health's (DH's) current international role and the development of the UK global health strategy
- Sets this in the context of UK health policy and the management and reform of the National Health Service (NHS)
- Describes how health systems in developing and developed countries alike face common issues – how to ensure standards and quality; how to focus on health improvement and not just services; how to enable patients and the public to exercise more control.

For more than 100 years … UK institutions and agencies have played a significant role in health in developing countries and continue to do so.

The UK has a long history of involvement in health in developing countries. As a colonial power it was responsible in many countries for administering health systems and founded or helped establish many hospitals, universities and medical schools and – in many cases – also provided staff. St Andrews Medical School, for example, provided the undergraduate pre-clinical medical training for Malawian medical students.

For more than 100 years a number of UK institutions and agencies have played a significant role in health in developing countries and continue to do so. The following list only describes a small part of this activity:

- **The London School of Tropical Medicine** was established in 1899 – the first institution to focus on health in the tropics, although initially largely concerned with promoting the interests of the colonisers rather than those of native populations. In 1924 it became the London School of Hygiene and Tropical Medicine, and as a leading school of international public health it is a model for others elsewhere and still a very influential body globally.
- **The BBC World Service**'s first shortwave transmissions were broadcast in 1925. It now transmits in 33 languages to many parts of the world. In May 2006 the BBC reported that the World Service's average weekly audience had reached 163 million people. An example of its work in health was given on page 39 in Chapter 3.
- **The UK Government** first recognised international development as part of its responsibilities in 1929 with an annual budget of £1 million. Health improvement has remained a part of its development activities ever since, through many changes of agency and a vast increase in funding.
- The predecessor of the current **British Council** was set up in 1934. It provides a wealth of networks and initiatives to improve health and stimulate scientific development. Last year the British Council worked in 109 countries.
- **The Medical Research Council** (MRC) was established in 1913 to tackle tuberculosis in the UK and began to work in the developing world after the Second World War. Its laboratory in the Gambia has now been established for over 58 years and provides many health services to local people in collaboration with the Government. Examples of its work are given on page 161 in Chapter 12.

The UK's international role in health

This history provides the background for the UK Government's current role in international health.

The UK Government works internationally to improve the health of the UK population and to contribute to improving the health of the rest of the world. The global health agenda includes health security, international development and trade, as well as public health and health protection and human resources.

In addition to contributing to the development of global health policy and practice, the UK undertakes research and works with others internationally to tackle global challenges – in combating obesity, for example, and preparing for pandemics, as well as undertaking healthcare reform.

Recognising the contribution of the UK Government to international health, the Chief Medical Officer and Medical Adviser to the UK Government, Sir Liam Donaldson, has set out proposals for a government-wide strategy in *Health is Global: Proposals for a UK government-wide strategy*. The report establishes the case for the whole of government to investing in global health and recommends the development of a UK global health strategy.[1]

The UK Government works strategically to improve global health through United Nations agencies such as the World Health Organization, the United Nations Children's Fund and the World Bank, as well as the European Union and the Commonwealth (see box below). It also supports a number of global health partnerships.

Commonwealth Secretariat

The health goals of the Secretariat for 2004–2008 are to strengthen health systems and programmes. The present programme specifically targets HIV/AIDS, maternal and infant health, and managed migration of human resources in health. The Secretariat collaborates with governments, international organisations, civil society and other stakeholders to address these priority areas.

As the largest international grouping within the World Health Assembly, Commonwealth health ministers have a unique capacity to define and shape global health priorities. Work to date has included a project to assist governments with contingency plans to mitigate the loss of staff in the public sector from HIV/AIDS, work with partners to improve midwifery skills in rural areas, and assisting countries to develop strategies and systems to manage migration of health professionals.

The Department for International Development (DFID), for example, supports the Global Fund to fight AIDS, tuberculosis and malaria, the Global Alliance for Vaccines and Immunisations, Stop TB and the Roll-Back Partnership. DH supports the Global Health Security Initiative and the World Alliance for Patient Safety.

The Foreign & Commonwealth Office, DFID, the Department of Trade and Industry, the Department for Environment, Food and Rural Affairs and DH all work bilaterally on global health issues. DH has a number of bilateral cooperation agreements to promulgate exchange of best practice, support training or encourage trade.

The inter-Ministerial group on health capacity in developing countries

In 2006, an inter-Ministerial group was established to consider how the UK can best contribute to strengthening health capacity in developing countries. It brings together the Department of Health, the Department for Education and Skills, HM Treasury, the Foreign and Commonwealth Office, the Home Office, DFID, the Northern Ireland Office, the Scottish Executive and the Welsh Assembly Government.

Terms of reference for the inter-Ministerial group

To consider how the UK can best contribute to strengthening health capacity in the developing world. This should be seen in the context of strategic global health developments, and in particular take account of the work carried out for the prime minister by Lord Crisp. The group should also take account of:

- Our overall international development policy objectives
- The potential of the UK NHS to offer support and practical know-how
- The potential of educational institutions to play a key role
- The potential of the immigration system in supporting migration that adds to the net total of skills in developing countries.

The group should make recommendations for action to be taken forward by the relevant departments within a coherent framework, and within available resources.

The establishment of the group recognises the contribution that different government departments have to make in strengthing health capacity in developing countries. Examples include the development agenda that DFID leads on; migration, visa and professional regulatory issues that the Home Office, Foreign Office and Department of Health are involved with; support at undergraduate and postgraduate level from the Department for Education and Skills; the diplomatic and economic policies of the Foreign Office and Treasury; and the experience gained by Scotland, Wales and Northern Ireland.

Its work will build on existing government policy frameworks including, for example, *Health is Global: Proposals for a UK government-wide strategy;* the Foreign and Commonwealth 2006 strategy, *Active Diplomacy for a Changing World;* the Department for Education and Skills 2004 strategy, *Putting the World into World-Class Education, An International Strategy for Education, Skills and Children's Services*, and the Treasury's *Globalisation and the UK: Strength and Opportunity to meet the economic challenge.*[1,2,3,4]

The UK's health policy and health systems

There is a firm foundation of values, legislation and history which is shared across the UK.

The UK's international health policy is designed to be consistent with UK domestic policy on health and the management and reform of the NHS.

UK health policy has developed extensively over the years. This short description aims to draw out only those key features of the system and the changes that are relevant to the later discussion of how UK experience and expertise can contribute to health in developing countries as well as to wider government international objectives.

There is no longer a single body of UK policy. Since the establishment of the National Assembly for Wales, the Northern Ireland Assembly and the Scottish Parliament in 1998, health policy is determined separately in each of the countries of the UK. The NHS is also managed separately in each country.

However, there is a firm foundation of values, legislation and history which is shared across the UK:

- Health policy embraces all aspects of health, from health protection and improvement to the management and delivery of services.
- The NHS is funded through general taxation and seeks to offer a comprehensive service to everyone – equally – regardless of the ability to pay.
- There are very strong links between the health service, education and research – which between them help support a strong bio-medical industry in the UK.

Each country also faces the same set of underlying issues that confront health services in every developed or developing country and which will help determine whether any of us can afford the standards of health and service delivery we desire:

- How to ensure the standard and quality of services
- How to focus more on health improvement and the prevention of disease rather than concentrate purely on health services
- How to involve patients and the public much more both in decisions about their own care and in decisions about services and policies.

Linked to all these issues are the questions of how to make health systems affordable and how to pay for them.

Differences between the UK systems

Since devolution the different parts of the UK have adopted different approaches to tackling these issues.

Each country has an overarching national framework that embodies the legislation, the values and the principles of the NHS and sets out the core structures and processes of the system. There is much in common between the four national frameworks, and some structures and organisations cover more than one country. However, within these frameworks the different countries have adopted different methods of delivering improvements.

England, for example, is mid-way through a ten-year programme of investment and reform. It has a radical programme which begins to use competition and market mechanisms alongside more traditional management methods and regulation – within the national framework – to drive quality improvements, to introduce new incentives for health promotion, to offer patients more choice and to secure value for money.

Scotland, on the other hand, has maintained a system which uses more direct management, benchmarking and quality control processes to make improvements and manage resources.

The national framework and the differing systems of delivery are summarised below. The English version is more like the 'commissioning model' and the Scottish one more like the 'management model'. In reality both of them – and the Welsh and Northern Ireland ones – are at different points between the two.

THE NATIONAL FRAMEWORK

The legislation

The values that must be adhered to

The standards that must be met
and/or improvement targets achieved

The independent regulation and assessment
of organisations, services and professions

The processes that must be followed and information
that must be provided as a part of a system

The common infrastructure that helps make it all work

Public and parliamentary accountability

Patient and public involvement

Financial allocations

COMMISSIONING MODEL

Primary care trusts (PCTs) in England commission public health and health services for a local population from a range of public and private sector providers to meet specified quality standards and cost levels.

Patients choose services from a 'menu' of the services commissioned by their PCT – and providers are paid for the services patients choose.

The whole system is, as far as possible, independently regulated.

MANAGEMENT MODEL

Unified NHS boards in Scotland are responsible for the delivery of health services to meet the needs of a local population.

Performance is managed by the Scottish Executive health department through performance targets and local delivery plans.

NHS boards are expected to meet specified quality levels.

There are regular independent reviews of the quality and governance of services.

The development of the commissioning model and the continuing evolution of the management model are of particular interest in those developing countries that modelled their systems on the UK's 1948 NHS – many of which have over the years followed and adopted subsequent changes in the NHS.

The contents of the national framework are perhaps of more general interest. The UK's NHS is a comprehensive national system which has evolved over the years a whole range of sub-systems or processes designed to make the whole system work effectively and meet quality and value-for-money standards.

Developing countries will, over time, want to develop their own national frameworks – without necessarily adopting a tax-based health system – and to create sub-systems and processes to address the same sorts of needs.

These include sub-systems and processes for:

- Improving quality and patient safety, and setting standards
- Regulation of organisations, services and professions
- Health protection, public health and emergency planning
- Providing common services, as diverse as blood collection, pensions or education and training
- Monitoring, surveillance and research and development
- Accountability to parliament, the public and patients.

This brief review of the UK's very sophisticated health systems may simply seem to be an illustration of how different a health service that spends more than $2500 a year per head of its population is from those described earlier which may spend as little as $5.

Some of the same methodologies and approaches, however, hold good whatever the spend. Indeed, quality control and regulation may be even more important in a very low-income country where the opportunity cost may be enormous.

The commercial use of UK experience and expertise

There is also, of course, an important market for the UK's health expertise, with agencies such as NICARE in Northern Ireland, HLSP and LATH (Liverpool Associates in Tropical Health) offering support on a commercial basis. HLSP also manages the contract for DFID's Health Resource Centre, providing advice and expertise in public health and health systems in low- and middle-income countries.

DH International, the trade promotion arm of DH, provides a link between the international community, the British health industry and the NHS. It has a key role in promoting the British healthcare industry and supporting commercial activities overseas, but also promotes links with the NHS, universities and others, particularly on international healthcare trade issues.

DH International works with a wide range of countries and has a memorandum of understanding with the Chinese Ministry of Health, for example, on healthcare development. The UK is now the largest European investor in China, and healthcare has become a priority area, with China–UK partnerships on system improvement, primary care development, and large building programmes.

Conclusions

The UK has had a long and enduring involvement with improving health in developing countries. This gives it a strong foundation to build on for the future.

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6

The UK Contribution – Making it Even More Effective and Sustainable

Summary

This chapter:

- Celebrates the extraordinary work done by so many individuals and organisations – and the goodwill, energy and passion that underpin it
- Recognises that the imagination and inspiration of these individuals and organisations can make an enormous contribution – alongside the systematic and planned approaches of governments and international agencies
- Acknowledges that these efforts can sometimes be fragmented and poorly thought through – and that many people want advice, help and support to make sure their efforts are appropriate and sustainable
- Argues that Government can provide a framework for action – which will allow organisations and individuals to contribute to a developing country's own plans
- Recommends ways to make it easier for individuals and organisations to contribute – so that they can make more impact and respond effectively to humanitarian crises.

The first part of this chapter is a celebration of individuals, organisations and partnerships.

Who can fail to be inspired by the British nurse or doctor who has worked a lifetime caring and teaching in rural Africa, or by the private British company that gives 10% of its profits to look after orphans and has made the Barnado-like pledge to provide support to them for life, or by the British public health worker in a camp tackling disease, dirty water and the awful aftermath of conflict?

Most importantly, who can fail to be moved by what they achieve? There are thousands of examples of clean water sources provided, patients treated, health workers trained, communities given confidence and resources and Indian 'railway children' rescued.

... clean water sources provided ... patients treated ... health workers trained ... communities given confidence and resources ... 'railway children' rescued.

These are all real examples and represent important different aspects of the way British individuals and organisations are contributing to improving health in developing countries – through clinical treatment, through teaching, through caring, through partnership and through applying the principles of public health.

Throughout our research for *Global Health Partnerships* we came across many thousands of people and organisations who provided voluntary support to developing countries – ranging from the Royal Colleges with their active international sections to hospital trusts, small charities and people who volunteered as individuals or as part of organised schemes.

There are a variety of ways in which UK people contribute

Some spend a period abroad at the start of their career, others in mid career or on retirement. Some volunteer, some are paid. Some return to the NHS with new experiences, others don't. These are a few examples.

Pam Wilson is a registered nurse who has worked for the NHS in Dundee for 25 years. She was granted a career break and is currently a VSO volunteer working as a clinical nurse tutor in Zomba college of nursing, Malawi. The Scottish NHS has maintained her pension payments and she will return to her post in early 2008 after almost three years.

She is also part of the Scotland Malawi Partnership and has helped to set up links between Scottish health centres and Malawian healthcare facilities. The goals are to build two-way educational, medical, nursing and patient group links using internet access to educational materials enjoyed by all Scottish practices.

Richard Jones is an experienced health service manager from Oxford. In 2003 he was seconded for a year to the Northern Cape Department of Health and Kimberley Hospital Complex with a focus on management capacity building, strategic planning and development of policies and procedures.

Richard's secondment resulted from a twinning partnership that was established in 1999 between Kimberley Hospital Complex and Oxford Radcliffe Hospitals. Initially the twinning consisted of exchange visits by senior management teams, with the chief executives, medical directors and chief nurses visiting each other's hospitals.

In 2002/3 this progressed to include clinical exchanges, with human resource development and education at its core. Some 28 nurses from the Northern Cape spent 6 months working clinically in the Oxford Radcliffe Hospitals. In addition, they undertook a programme of learning and project work for implementation back in their home environment. Subsequently three nurses from Oxford spent a month working in Kimberley on specific projects on the children's ward, in the accident and emergency department, and in the neurosurgery department.

After a time back in England – working again for the Trust in Oxford – Richard is returning to South Africa to continue his career there.

'Quasi-retirement' is how **Professor Sir David Hall and his wife, Dr Susan Hall**, refer to their new life in South Africa. David is a past president of the Royal College of Paediatrics and Child Health; Susan is a consultant in infectious disease epidemiology. They explained: *"Thirty years ago we worked at Baragwanath Hospital in Soweto, Johannesburg. At the time it was the biggest hospital in the Southern hemisphere with 19,000 births a year. We spent three years there – Sue set up a women's health and family planning service with nurse practitioners, the first in Africa – before we returned to the NHS."*

There are very many organisations large and small that provide help, support and, often, direct services to people in health and healthcare. Some of these are British, whereas others are international and involve volunteers and workers from across the world. Some like Oxfam, Red Cross and Médecins sans Frontières provide or support services, whereas others like One World Action offer advocacy and help empower people to effect change. Just a few examples are described below.

Voluntary organisations ... can bypass burdensome regulation and corrupt and disabling systems.

UK organisations range from the large well-known non-governmental organisations (NGOs) to many thousands of small organisations that provide education and support, advocacy for particular conditions and direct service. These few examples illustrate something of the range.

The Liverpool School of Tropical Medicine (LSTM)
LSTM has developed close ties with the **Institut Pan-Africain de Santé Communautaire** (IPASC) through academic appointments and postgraduate training of senior IPASC staff. A small UK charity helps support its activities in the Democratic Republic of the Congo (DRC). North eastern DRC has experienced a series of intense inter-tribal conflicts over the past six years which have resulted in massacre and disruption of healthcare and basic infrastructure. In this environment, a locally managed team has delivered technical college and university level training in maternal health care, primary health care, HIV/AIDS support, malaria control and natural medicine programmes. The team and students have fled from armed conflict twice in the past six years, each time starting again almost from scratch. They now have a more stable base in Aru, near the Ugandan border with the DRC province of Ituri.

The Fistula Network
The Fistula Network, set up by the London-based International Federation of National Societies of Obstetrics and Gynaecology, brings together a number of different organisations including the African Medical and Research Foundation (AMREF) and the United Nations Population Fund (UNFPA) both to provide and to campaign for better services for women affected by this disabling condition.

Working with AMREF and the International Federation of Gynaecology & Obstetrics (FIGO) in Tanzania, doctors from the UK, Holland, Greece and Tanzania have increased training and service capacity in the country. In addition it is preparing a competency-based training manual suitable for nurses as well as doctors.

Safe Hands, another small UK charity, has worked alongside it using a combination of training videos, still photography and patient educators to promote prevention among women at risk.

Mercy Ships
UK doctors also contribute to Mercy Ships, which is a global charity engaged in bringing humanitarian aid to developing nations. Founded in 1978, it operates a fleet of hospital ships to provide free healthcare and community development to developing nations. It has had an impact on more than 1.7 million people; delivered more than $35 million of medical equipment, hospital supplies and medicines; and completed more than 800 construction projects such as schools, clinics, orphanages and waterwells. The ships have visited 555 ports in 70 different nations and the organisation also operates two land-based centres in Sierra Leone.

One of the great values of voluntary activity and voluntary organisations in any society is that they can reach places and people that government and large organisations cannot. They can bypass burdensome regulation and corrupt and disabling systems. They can also draw attention early to problems, pioneer solutions and advocate for the powerless. The UK's own history is full of examples from Octavia Hill to Mencap and Amnesty International.

Many of the international NGOs active in development are explicit about their need to operate freely and at some distance from governments in order to be effective and deliver services to the poorest and most needy people.

However, this should not in any way absolve governments of their own responsibility. Oxfam and WaterAid in a recent publication make the argument that all governments should be held to account for their responsibility to ensure basic health, education and environmental services are provided to their people.[1]

Individuals participate in these organisations for a variety of personal reasons, humanitarian, political or spiritual. Religion motivates many people and faith groups play an enormous role in providing for health with many mission hospitals, large faith-based organisations like the Aga Khan Foundation and individual clinicians such as the nun nursing in the remote Tanzanian bush. The scale of the religious contribution is illustrated by the fact that in Kenya 18% of institutional deliveries occur in faith-based hospitals.[2]

The challenges and difficulties

There are, however, a range of difficulties and challenges that individuals and organisations face in carrying out this work. They fall into two groups:

- The first, more NHS specific, is about providing a clearer framework for action, making it easier for individuals to volunteer and for organisations to partner with others in developing countries
- The second, more general one, is about making sure that these diverse efforts are as effective and sustainable as possible – providing some coordination and support.

The NHS – a framework for action

Many people in the NHS told me that they needed greater clarity about policy and arrangements for involvement in international development and talked to me about difficulties people faced in volunteering, in returning to the NHS and in funding.

Dame Gill Morgan of the NHS Confederation told me: *"We need to find ways of making this sustainable for individuals and organisations"*. Others at a meeting she hosted for this report told me: *"The NHS needs an adequate framework within which to make decisions"*, *"We need to build on what's already happening"*, *"We need to make sure there is proper preparation and induction – and de-briefing"*, and *"We need ways of getting DFID involved in discussion with us"*.

The starting point for this must be greater clarity about the position of government and the working relationships between the different government departments. Whereas the relationship is generally good, there needs to be greater integration if the UK's development effort is to make more use of health experience and expertise.

Recommendation 1
I am therefore recommending that 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.

It is also very important that NHS organisations understand development and how they can link their efforts in with others from the UK and internationally. The most important point here is that individuals and organisations need to do their best to set their efforts in the context of the country's poverty reduction strategy and/or the country health sector plan and to seek to link with others doing similar work.

The UK Government has made a commitment to expand links between the NHS and developing countries,[3] and against this background, the NHS centrally working with the Department of Health and DFID would have responsibility for setting out an NHS framework.

Recommendation 2
I therefore recommend 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 to include the contribution to international development in its annual assessment process.***

Providing better information, communication and coordination

It is also important to provide support for individuals and organisations outside the NHS who may be able to contribute to improving health in developing countries. They too face difficulties.

Not all projects are successful. Progress can be very slow and easily wiped out by time or, worse, conflict. As noted earlier, Africa in particular is littered with the debris of past projects and well-intentioned charitable efforts. Sometimes these efforts seem misguided, amateur and ineffective.

Sometimes, too, projects are too driven by Western attitudes and behaviours to have any positive impact. I recall listening with growing horror to four foreigners talking in a Ghana hotel and saying: *"It's wonderful here. You can do what you like and you can teach what you want."*

It is certainly true that in some parts of the world you can operate largely free from constraints – and free from responsibility and accountability. This freedom may have some benefits, but it is very open to abuse – conscious or otherwise. The lack of regulation or ways of accountability mean that untrained people can provide inappropriate treatments, post-surgical complications can be left unresolved and money can be spent on things that aren't needed.

UK organisations are very conscious of these issues – keen to make sure they understand needs, wanting to know what works, concerned to work with local people and determined to focus on practicalities. They want to work responsibly – knowing the evidence – and to work accountably, linking in wherever possible to the country's own strategies and the wide efforts of the international community. Time and again I was told by people that they wanted advice and information and to learn from others about how to make their work really count.

However, this can be very difficult to do. Smaller organisations, in particular, may find it difficult to get information. They may also find it almost impossible to make contacts with the right people in authority in the UK or the developing country. Very often, I was told, those in authority weren't interested in – or perhaps, more often, simply didn't have time to deal with – the efforts of small organisations.

A number of organisations – notably the UK Government through DFID – do publish information about how to become involved in international development and signpost individuals towards reputable organisations. However, my discussions and observations over the last few months convince me that more needs to be done.

The other side of this discussion, of course, is that governments in the UK and developing countries don't know what support and resources they could call on from volunteers and organisations. On the one hand, individuals and organisations find it difficult to get information about needs and opportunities; there is some duplication and wasted effort and ultimately some frustration. On the other, governments and organisations looking for volunteers or help from the NHS have no central point of contact and can waste time and effort in looking for appropriate expertise.

Recommendation 3

I am therefore recommending that 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.

The centre should be small, attached to an existing organisation and build on the arrangements in Scotland and on DFID's existing agreement with Crown Agents.

Global health partnership centre

A global health partnership centre should be established as a 'one-stop-shop' source of information for governments and health organisations in the UK and internationally, which would actively seek to make connections and promote and share good practice and learning. It would help effective delivery of government international health commitments, notably the White Paper commitment that the UK will help partners in Africa to help solve their staffing crisis through training and support for higher education, and expanding links with the UK NHS.

Aims

- To help coordinate and facilitate the contribution of UK health expertise to developing countries and facilitate effective international health links
- To provide a focal point for UK and international agencies, and developing countries, and provide coordination between agencies

- To maintain an overview of strategic needs globally, and provide support and advice on where the UK could best support developing countries
- To promote global health work, including the value and opportunities, within the UK health, education and professional sectors.

Responsibilities

- Provide a forum for information exchange between partners, and coordinate work across the UK through regular communication and a steering group of key agencies
- Provide a focal point for individuals and agencies in the UK, including government, NHS, academic and professional bodies, and regions; and for international agencies, including in international health emergencies, and put people in touch with each other
- Act as a knowledge bank on the needs of developing countries, and maintain information on opportunities, including humanitarian emergencies, to help provide strategic direction for UK health support
- Maintain an overview of UK health partnerships with, and support to, developing countries, including NHS, academic and training links
- Create access to a register of trained individuals and organisations from the NHS, assist with matching individuals and organisations, and signpost training for individuals who want to work overseas – possibly through an electronic global health exchange
- Promote the value of global health work, and stimulate the implementation of policy advice, through regular communication to stakeholders
- Promote good practice and learning, and facilitate information exchange between key bodies on health links, research and service development, for example.

The problems of matching need with offers of help are illustrated well in the case of equipment and books. Many organisations in developing countries are desperately short of equipment of even the most basic sort – beds and theatre sets as well as more complex things – and hungry for medical journals and books. Many UK organisations are only too willing to donate them but often find obstacles in finding the right recipient, in transport and in negotiating the way through customs.

There are a number of specialist existing organisations that provide excellent services, such as Book Aid, and have made extensive contacts in developing countries. However, I believe these efforts too could be enhanced by using electronic methods of putting people in touch.

Recommendation 4
I therefore recommend that 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.

There will need to be rules developed – just like for eBay – to ensure quality and probity but, if it could be made to work effectively, this idea could vastly expand the contacts and the relationships between individuals and organisations around the globe.

Providing support for NHS staff who wish to volunteer

There are many individuals who want to work for a period of their lives in developing countries – some when they are young, some when they take a career break and others on retirement. Many of them want to come back to the NHS at a later date.

Many find their own ways to do this; but there are some common barriers and constraints – some are personal such as families, finances and mortgages – but others, such as release by employers for study leave or career breaks and maintaining pension and accreditation continuity, are organisational and general.

Voluntary organisations and NGOs also find difficulties in recruitment without any clear statement from the NHS or departments on the appropriate arrangements or even on how to contact potential volunteers.

The Scottish Executive has tackled this by agreeing a pilot programme with VSO that involves releasing 20 volunteers, with a guarantee of re-employment at the same level on return. It has also negotiated arrangements with the NHS Pensions Agency to maintain their pension continuity. This provides a useful model for the rest of the UK.

VSO has now put forward proposals for a similar scheme in England and described how it could go from supporting the current 50 health volunteers at any one time to supporting 500 in five years' time, with each person volunteering for between 3 months and 2 years. These positions could be used strategically, as I will describe in the next chapter, to meet identified needs such as those for nurse tutors or public health specialists.

The success of this scheme will rely on employers being willing to release – and re-engage – people. Recognising that this may be difficult for individual

employers, the Scottish Executive has accepted the responsibility for re-engagement at a national level, confident that there will always be a sufficient pool of vacancies to manage this. A similar arrangement at strategic health authority level could be made in England.

Recommendation 5
I therefore recommend 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.***

In order to make these recommendations work, DFID may need to state that it values the contribution of health sector volunteers, and encourage 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 want to volunteer to help with humanitarian emergencies – and many can offer very valuable assistance. However, it can be very difficult to match need with volunteers. Following the Pakistan Earthquake in October 2005, several hundred UK health professionals arrived in Pakistan along with thousands from other countries. Some proved very useful – and some became an additional part of the problem.

Since then the UN has established 'clusters' of organisations that will take on responsibilities for different aspects of the humanitarian response – and the major international NGOs have agreed their roles and responsibilities. In health, the World Health Organization is the lead agency and works with the relevant NGOs. It will assess, in conjunction with the health authorities in the affected countries, what external health skills may be needed and will channel calls for help accordingly.

Experience from Pakistan and elsewhere has shown the importance, in addition to this coordination, of finding volunteers with the right skills, who have had some induction or relevant training and who work as part of an experienced organisation or team.

We looked, as part of this review, at whether it would be sensible to set up some special NHS arrangements to provide humanitarian assistance but concluded that more would be achieved through making it easier for NHS staff to contribute through established organisations.

Recommendation 6
I am therefore recommending 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.***

Global health experience for UK health workers

... there is a strong case for health workers to gain experience in developing countries – and ... a better understanding of public health early in their careers.

Involvement in health internationally has, over the years, benefited many UK health workers and – through them – benefited the UK. There is a great deal of continuing interest today in training and working in developing countries among health workers in the UK.

Individuals gain a breadth of experience, learn new skills and, often, gain greater adaptability and self-reliance. The UK benefits from having individuals who understand wider international health issues and who can help it to deal with infectious diseases and global health problems, care appropriately for its citizens of overseas origin and manage diseases and conditions that are uncommon in the UK.

It is also important at an early stage in training for health professionals to see for themselves the importance of public health issues. This is very clear in developing countries, but can be obscured in the UK. It is also important for them to see different ways of working and different groups of staff at work.

There is also some evidence that the introduction of an international dimension into the teaching of public health in the UK improves training, motivation and subsequently recruitment of students into careers in public health.[4]

For all these reasons I believe there is a strong case for health workers to gain experience in developing countries – and with it, a better understanding of public health early in their careers. I believe that UK educators and employers should encourage this and make it easier for it to happen.

Current activity

A large number of people do find ways to gain experience and training abroad; however it is becoming increasingly difficult for doctors particularly, as their training becomes more restrictive.

For other professions – with shorter training periods – it is largely a matter of employers being willing to release people and/or re-engage people when they return from abroad. Several already do so on a local and individual basis.

The recommendations made earlier about providing a new framework for the NHS, creating a new relationship with VSO and allowing for pension continuity under the right conditions should help this to happen more generally. Ultimately, however, it remains the responsibility of individual employers to make decisions.

Turning to medicine, a significant number of medical students spend part or all of their elective period on a project overseas, many of them in a developing country. There are now also intercalated degrees offering international health programmes in London, Leeds and Bristol, which together produce about 100 graduates every year.[4]

Graduates from these programmes and other students and doctors with international health experience have formed Alma Mata, an active network of over 400 health professionals and students interested in international health.[5] A thriving student network, Medical Students International Network (MedSIN), has also existed for about 10 years, and has advocated the introduction of international health in medical school curricula across the UK.[6]

In 2005 and 2006, Alma Mata surveyed its members. The results indicated considerable demand among senior medical students and junior doctors for global health training and career pathways, after graduation and before beginning work within the NHS. There was a high demand for training in the foundation years,

with priorities identified as training in infectious diseases, emergency medicine, obstetrics and gynaecology, paediatrics, and public health.[7,8]

The surveys showed that, although 86% planned to work with humanitarian or development agencies in the future, 76% of respondents said they planned to follow a UK-based career with some periods of overseas work – indicating that such training would provide benefit for the NHS in the longer term. Some 71% were interested in specialist training in public health; 86% of respondents agreed they would be more likely to opt for this training if it included a period of overseas training.

Two issues arise. The first, which applies to all professions, is how to ensure that the developing country itself benefits from these arrangements. The second is how to make it easier for students and trainees to gain this experience at a time when training is becoming more restrictive and how to allow professionals to retain accreditation during long periods abroad.

The benefits for developing countries need to be identified and clearly understood. Representatives of some developing countries raised concerns with us about the length of time and the experience that students and trainees bring. *"Placements should be for at least 3, 6 or 12 months,"* we were told by one health minister. The Botswana minister of health told us: *"A priority for us is trained staff. Our country can end up supporting UK staff if they come only with limited training."*

These comments make it clear that these elective visits and training should be seen as part of the wider framework proposed earlier. They must be very carefully organised – perhaps linked into a continuing programme or part of a wider link with an institution in the developing country – so that students undertake tasks that contribute and are mutually beneficial.

The particular issues in medicine require a number of authorities to work together. They also require will and imagination to make this happen. Many doctors of great experience – some of whom hold office in the royal colleges and other organisations – have suggested ways in which this can be made to work and pointed to examples. There are Senior House Officer (SHO) rotations, for example, with Ethiopia and young doctors being supervised by exceptionally experienced doctors abroad.

There are some good examples where this has already been achieved.

The Royal College of Paediatrics and Child Health (RCPCH) has offered UK trainees the opportunity to train overseas in developing countries and have this recognised as part of their training. This was done through two schemes:

- The RCPCH/VSO fellowship scheme – a joint venture that accredited one-year training placements in developing countries as part of higher specialist training in paediatrics, approved by the Specialist Training Authority (STA).
- The RCPCH has also accredited two overseas centres in Kenya and Malawi, which have been recognised by the college for training. These have been inspected by RCPCH and recommended to the STA for training accreditation.

The introduction of Modernising Medical Careers could provide the opportunity to reconsider how international medical training and overseas work might be included in the higher medical training programmes – both in the foundation years, and within specialist and general practice training.

However, it will require the royal colleges, deaneries, and the Postgraduate Medical Education Training Board (PMETB), with whom all training recognition now rests, to look at the opportunities for overseas training and accreditation, both as part of prospectively approved training courses for the CCT, and for equivalence training to gain Certificates confirming Eligibility to join the Specialist Register (CESR) using the Article 14 route.

All UK health professionals working abroad, however, have a need for revalidation and regulation so that they can return easily to the UK. This too will require the relevant UK authorities to work together to introduce new arrangements.

Recommendation 7
Against this background, I recommend that 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***
- ***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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7

Strategic Partnerships

Summary

This chapter:

- Describes some of the many partnerships and links that exist between UK organisations and those in developing countries
- Shows how people from developing countries and now living in the UK are heavily involved and that this can bring benefits for looking after the health of UK citizens
- Argues that there is mutual benefit derived from many of these partnerships
- Discusses how the private sector can be involved – with a mix of commercial and humanitarian motives
- Recommends that the UK actively uses the development of these partnerships as a means of driving and sustaining improvement.

Partnerships between universities, links between hospitals, the partnership between Diabetes UK and the Mozambican Diabetes Association (AMODIA), the UK agreement with South Africa, and the Scottish one with Malawi are all examples of the very many partnerships already existing between UK organisations and institutions in developing countries.

These partnerships operate on a mutual basis through exchanging information and staff, and through identifying needs in one partner and attempting to meet them with help from the other.

Whilst there is mutual benefit, successful links are based firmly on the needs of the partner in the developing world and on practical and direct help in, for example, providing training, staff and equipment from the UK partner.

An example of a long-running, successful link is that between Hereford Hospital and Muheza in Tanzania.

Over more than 20 years, staff from each have visited the other. Each year Hereford Hospital responds to requests from Muheza and sends staff for a period – who over the years have included laboratory staff, a plumber, IT staff and a finance officer as well as nurses, health visitors, radiographers, physiotherapists and doctors – and collects and despatches a container load of the donated equipment that has been requested. More recently, a retired physician from Hereford has worked as the medical director in Muheza.

All this activity is supported by the staff of the hospital who fund-raise and give their time voluntarily.

International Diabetes Federation (IDF)

Twinning initiative

One of the main objectives of the Task Force on Insulin, Test Strips and Other Diabetes Supplies is to increase accessibility to insulin and diabetes supplies in the many countries in the world where this is lacking. To contribute towards achieving this aim, the Task Force has developed the Association Twinning Initiative (ATI). This initiative aims to encourage IDF member associations in developed countries to 'twin' with a select number of associations in developing countries in order to initiate and implement projects to improve access to insulin and diabetes supplies.

Diabetes UK

In October 2006 a visit by the project coordinator and members of Diabetes UK to Mozambique took place to investigate the possibility of Diabetes UK twinning with AMODIA under the umbrella of the ATI.

These sorts of partnerships are increasingly popular around the world and in all different sectors. The UK Government promotes partnerships in higher education, as well as in schools. The Department for International Development's (DFID's) Higher Education Links scheme, and the new Development Partnerships in Higher education programme (DELPHE), for example, were established to support higher education partnerships, including some health partnerships.

Since 1997, these schemes have supported over 100 higher education partnerships in health. In addition, under the England-Africa Partnership scheme (EAP), the Department for Education and Skills (DfES) is providing £3 million until March 2008, to promote and support partnerships between higher education institutions in England and Africa. The scheme is designed to help strengthen capacity in African higher education through innovative partnership projects across a range of subject areas.[1]

The French Government promotes and funds links between French hospitals and those in the francophone world. The Portuguese-speaking countries have developed a network of activities, including linking organisations to support developing countries improve the health of their populations.

There are also an increasing number of community-based partnerships. The UK One World Linking Association (UKOWLA) has 350 members, including towns, schools, local authorities, health groups, faith groups, diaspora groups and other community-based organisations.

The Tropical Health and Education Trust (THET) plays the leading role in supporting links between NHS organisations and partners in developing countries. It is able to provide advice and support to new links and – thanks to a DFID grant – offers a small amount of seed corn funding.

In a recent survey[2] of 101 organisations involved in links, THET found they were supporting 91 links between them. Of these, 64 are linked with institutions in Africa. The largest numbers are in Malawi (18 including 11 from Scotland), Uganda (8), South Africa and Zambia (6 each) and Tanzania (5). There are also 18 in Asia, including 9 in India.

Several of these links involve more than one party. Medical Service to Romania, for example, facilitates links between a Romanian health authority and three UK hospitals. Elsewhere, there are partnerships that involve several partners from developing countries with UK and other developed country organisations. So-called south–south partnerships – between developing countries – have an important part to play in sharing learning and best practice.

The THET research has not picked up all the links that exist at a specialty or management unit level. Many teaching hospitals have long-standing links: for example, the Institute of Child Health at University College London (UCL) is involved in research and service links in several countries. Addenbrooke's Hospital has more recently brought support for several of its links into a new charity 'Addenbrooke's Abroad'.

The THET research has also shown the distribution of links by type of NHS body, the type of activity undertaken and the sorts of input made by the UK institutions.

Table 3: Distribution of UK links by NHS body

Type of body	No.
Acute trusts	56
Primary care trusts and health authorities	11
Mental health trusts	8
Ambulance trusts	2
University or professional association	13
Specialist trusts	1
Total	91

The types of activity undertaken range across the whole of health and healthcare with, for example, some long-standing links in mental health as shown in Table 2.

Table 4: Distribution of link activities by health service discipline

Health service discipline	No.	Percentage
Healthcare delivery	43	93.48
Public health	18	39.13
Health leadership and management	14	28.26
Medical curriculum development and external examining	6	13.04
Laboratory research	7	15.22
Others	6	13.04

Table 5: Inputs by partner institution

Sample	UK (n=42)		Less developed countries (LDCs) (n=10)	
Input	**No.**	**Percentage**	**No.**	**Percentage**
Teachers/trainers	35	92.11	3	37.5
Training material	23	60.51	2	25
Technology	15	39.47	0	0
Health literature	12	31.58	0	0
Better reputation by association	9	23.68	2	25
Researchers	7	18.42	2	25
Students	7	18.42	6	75
Stronger accreditation	5	13.16	1	12.5
Other	7	18.42	1	12.5

Source: see Reference 2

In the survey, some concerns regarding maintaining links were expressed. Among developing world partners, the additional pressures on staff-time, financial constraints, and difficulties with accessing facilities to maintain communication with the UK were all mentioned.

Mutual benefit

Many people stress the mutuality inherent in these partnerships.

Michael Parker, Chair of King's College Hospital, whose Somalia link is described later in this chapter, argues that *"working with partner organisations is 'capacity building' for our people and our hospital. They learn and they develop as individuals and bring that learning and development back to London."*

> ***... health workers ... learn resourcefulness, adaptability, cross-cultural awareness and a rich experience.***
>
> **Eldryd Parry**

Professor Eldryd Parry, who first worked in Nigeria in 1960, through an NHS secondment, and founded THET in 1988, described the value of links in a speech in April 2006: *"Through Links, the very health workers on whom [we] depend and who are in health care's front line, will learn resourcefulness, adaptability, cross-cultural awareness and a rich experience. It is they who return to the tasks in [our] linked hospital with freshened motivation and invigorated enthusiasm."*

For the organisations surveyed by THET, the three main benefits were seen to be about reputation, professional development and the learning of new healthcare delivery methods,

Or, as the Hereford–Muheza Link leaflet for Hereford staff puts it succinctly, *"The Hereford–Muheza Link challenges your ideas. [It] will stretch your mind. Link visits may change your life!"*

These links are also important in the wider context of building partnership around the globe – or, as BUILD, a coalition of non-governmental organisations (NGOs) building partnerships and links, says, *"Barriers of prejudice and misunderstanding can only break down when we engage and create partnerships at grassroots level."*[3]

These are powerful statements and help explain why so many NHS organisations have decided to set up links and join partnerships, with increasing numbers as awareness of the possibilities has grown. The NHS Confederation has set out the reasons for this, and says: *"NHS employees are characterised by a powerful sense of vocation and a desire to improve the health and wellbeing of communities. The opportunity to provide support to healthcare systems and communities in developing countries helps reinforce these values, offers rich scope for professional development and the satisfaction of a meaningful personal contribution. The NHS employer usually welcomes back a highly motivated member of staff who has grown personally and professionally, to deliver better services for patients in the UK. In this sense, there is a strong business case for NHS employers."*

Whilst I have concentrated on NHS organisations here, elsewhere in the report I describe the role of education institutions and private organisations in development. In each case they see benefit in reputation, in terms of their 'Corporate Social Responsibility', in the motivation of their staff or, in some cases, the more direct benefits of influence and of commercial advantage.

The role of people from developing countries living in the UK

There are many people from developing countries in the UK who can both contribute to improving health in developing countries and contribute to improving the appropriateness of healthcare in the UK. Surinder Sharma, National Director of Equality and Human Rights at the Department of Health, England, has expressed the point that in the UK there are many people born in developing countries but now working in the NHS and Department of Health who have an understanding of the culture, language, systems and social conditions of both the UK and their indigenous countries. He suggests that these skills could be much better used in exchange programmes, healthcare or educational development, in a two-way process.

There are also a number of organisations for people from developing countries, with some like Africa Recruit, for example, ambitious to play a role in all aspects of international development. Africa Recruit aims to build capacity in Africa by focusing on human and financial resources. It uses networks to provide a market place for job seekers and employers, and facilitates the identification and sharing of good practice. Others like The British Association of Physicians of Asian Origin (BAPIO) exist to provide support for particular groups working in this country – in their case doctors – and are very keen to contribute to the UK's health systems.

The involvement of these groups helps ensure that partnerships are truly two way and mutual and can provide the motivation for partnerships. The Learning Disability Department of Leicestershire Partnership is proposing to work with three institutions in India to build capacity across India in learning disability. The lead in the UK was born in India and is chair of the Learning Disabilities Section of the Royal College of Psychiatry. The Malawian diaspora group Mahecas (Malawian healthcare support), based in Nottingham, has provided support to the links between Harrogate PCT and Zomba Mental Hospital and Lilongwe Central Hospital and South Tees Hospitals NHS Trust.

These groups and the partnerships can also help with tackling the health issues of British citizens of overseas origin. Apnee Sehat, described below, was set up by Dr Shirine Boardman to tackle diabetes in people of South Asian origin.

Apnee Sehat

South Warwickshire Primary Care Trust's 'Apnee Sehat' (Punjabi for 'Our Health') project was developed in response to the greater incidence of heart disease and diabetes in the South Asian population.

The project aims to tackle this problem by:

- Identifying cardiovascular and metabolic risk factors, such as abdominal obesity
- Educating the community on health risk factors pertinent to their genetic predisposition and, often, lifestyle choices
- Supporting behavioural change to improve health outcomes
- Delivering a tool for better health that is culturally sensitive, easily understandable and transferable.

Working with the local South Asian population across traditional boundaries to raise awareness of obesity and the consequences of that condition on their health, the project aims to prevent serious health problems related to obesity and associated risk factors. The project engages the public with advice on culturally acceptable healthy recipes and ways of increasing exercise, as well as information on the health benefits of spices, minerals and vitamins.

Support for developing countries is also an important issue for some of the black and minority ethnic networks established in the UK. A good example is the African Health Policy Network (AHPN), an alliance of African community-based organisations and their supporters working for fair policies for people living with HIV/AIDS in the UK. Although AHPN's major focus is HIV and the sexual health of Africans in the UK, the network also works to promote Africa's development.

These groups are helping to contribute to the development of an equal opportunities culture in the NHS and ensure that the NHS is able, culturally as well as clinically, to provide appropriate care for all the citizens of the UK.

Strategic partnerships

These partnerships and links can bring clear benefits – to all parties – and help develop longer-term relationships and mutual understanding across the world. They can also have a strategic role as instruments of change and as a means of sustaining gains and progress.

One of the key aspects is the ability to provide continuity. Sir Andrew Haines, Principal of the London School of Hygiene and Tropical Medicine, told me that he believed such institution to institution links were very important in

... partnerships and links can bring clear benefits – to all parties – and help develop longer-term relationships and mutual understanding across the world.

... institution to institution links are important in ... providing an enduring focus for development.

Sir Andrew Haines

development because they could provide an enduring focus for development. Once established, they need not be dependent on individuals or on the politics of the day, and could bring together many different organisations and individuals who wanted to contribute.

The example of King's College Hospital NHS Trust is very instructive in this regard as it goes beyond the purely institution to institution link and has grown to embrace a far wider partnership.

In 2000 King's, together with THET, began working with a number of Somaliland organisations. Over the last six years this work has involved training health professionals and tutors, refurbishment of the A&E Department at Hargeisa Group Hospital, establishment of a revolving drug fund and much more. King's has also built up strong local relationships and a high level of trust over this period.

In June 2006, the Government of the Somali Republic and the Ministry of Health and Labour requested help from King's/THET to support development of the health sector, with the main areas of intervention identified as:

- Provision of financial and technical assistance to develop an integrated and coordinated approach to provision of an essential health package (EHP)
- Strengthening capacity of health systems to deliver an EHP
- Support to human resource development
- Support to address the high levels of maternal and newborn morbidity and mortality.

In response, King's and THET have now partnered with the Royal College of Obstetricians and Gynaecologists International Office, Health Unlimited and Save the Children UK to propose a much larger-scale programme with the ambitious aim of *"Health Systems Strengthening in the Somali Republic through phased interventions with an initial focus on Somaliland"* .

While this latest development in the partnership is still in the planning stages, it does illustrate a number of points about the strengths of partnerships of this sort. It is built on shared experience and the trusting relationships this has generated, institutional links have grown to involve many partners – who can bring in different resources – and it explicitly responds to needs identified in the country by its government and others.

This and other examples suggest that partnerships and links could be a very important lever for strategic change. There are many examples of successful partnerships and links where clear improvements have been made. However, there is a need for an evaluation of their impact on a whole system.

National partnerships

In 2003, the UK and South African governments agreed a Memorandum of Understanding (MOU) to facilitate *"the reciprocal educational exchange of healthcare concepts and personnel between the two countries"*. It was part of a joint response to concerns expressed by the South African government about health care staff migrating to the UK, and complemented other wider UK workforce policy initiatives which reduced the migration of South African nurses to the UK – and demonstrated the UK's commitment to 'ethical recruitment'.

The South African Health Minister, Dr Manto Tshabalala-Msimang, praised the MOU in a budget speech to Parliament in June 2006: *"We have an agreement with the UK through which health workers can work in UK hospitals and return to the public sector without loss of employment or status. There have been major achievements as a result of this agreement."*

The MOU focuses on the sharing of expertise and information in several key areas, and on opportunities for time-limited placements in the other country. As part of this, a regular programme of workshops has been developed in South Africa, and links have been developed based on requests and identified needs, including a number of twinning arrangements between individual institutions. The workshops have addressed topics identified by the South African Health Minister, including the National Institute for Health and Clinical Excellence (NICE) – and the scope for adapting NICE guidelines for use in South Africa; the Health Protection Agency (HPA) – including epidemic outbreak preparedness, antibiotic and anti-drug resistance; and *Improving Working Lives* – including recruitment and retention of healthcare staff.

As part of the time-limited placement opportunities, South African figures suggest that in the nine months after the MOU was signed some 70 UK health professionals went to South Africa, a further 259 went on short-term placements in the following nine months, and 256 in the year after that. A pilot cohort of 18 South African nurses, selected by their health department, also worked at King's NHS Trust, London, for two years before returning to South Africa in 2005.

The Scottish Executive set up a similar arrangement with Malawi in 2005, which is designed to build on a shared wish to engage in a reciprocal partnership based on sharing experiences and skills. This strategic agreement plays to the strengths of both Malawi and Scotland, is very successfully focused on a relatively small number of issues, and the early signs are that it is going to be very effective.

Both these examples were created for a very specific reason: the South African one due to the concerns over migration and the Malawi one because of the historical connections – via David Livingstone – with Scotland. Each appears to have been successful within its own terms. Further such agreements would also need to have some similar starting point which would distinguish the agreement from the routine arrangements which the UK – via DFID – has with many other countries.

It is noticeable that the Department of Health (DH) took the lead in South Africa, in cooperation with the Foreign and Commonwealth Office (FCO) and DFID, and the Scottish Executive initiated the Malawi agreement. Both have been effective, but there is scope to consider further how they might fit as part of the UK's strategic programme of international development.

The private sector

The international private sector and the non-health private sector in developing countries also have important roles to play in wider partnerships. Many international companies are already active – both the Association of the British Pharmaceutical Industry and the American Pharmaceutical Group in the UK support the work their members are doing in providing services, drugs, donations and training. They have also stressed the interest companies have in doing more in partnership with others.

Their motivation is clearly both humanitarian and commercial. As Dr Jeffrey Sturchio of Merck says: *"Merck believes that responding to global health challenges such as HIV/AIDS is not an option, but rather a strategic and humanitarian necessity. Indeed the outcome of the fight against HIV/AIDS will be a key factor in defining in many developing countries the political, business and economic climate for companies like Merck in years to come."*[4]

True to this sentiment, Merck has indeed been involved for 20 years in partnerships to improve health in Africa, with impressive results in its partnership with the Government of Botswana and the Bill and Melinda Gates Foundation in the African Comprehensive HIV/AIDS Partnership in Botswana.

All of these points suggest that the private sector needs to be engaged in both local and international partnerships to strengthen health systems.

A strategic approach across government

The last chapter recommended strengthening ministerial oversight, developing stronger links between DFID and DH and creating a Global Health Partnership Centre. The discussion in this chapter suggests that the UK has the opportunity to use partnerships more strategically to drive change and improvement.

These partnerships can operate at many different levels – the community an institution, a school or a whole nation. There is evidence that countries welcome these partnerships. Zambia, for example, is one of several countries where the health Ministry has asked THET to develop links between Zambian institutions and UK ones. In another example, in 1998 South Africa asked a joint DFID/EU initiative to identify UK partners (health authorities and health trusts) for links with South African health departments and secondary and tertiary hospitals.

Strategic Links between the Ministry of Health in Zambia and the UK National Health Services

Dr Simon Miti, Permanent Secretary, Ministry of Health, Zambia writes:

The health sector in Zambia is facing a human resources crisis. The main contributing factors to the crisis include:

- High attrition among core health workers from the public health service to overseas, mainly the UK and the private sector non-governmental organisations (NGOs). Death due to HIV/AIDS is another contributing factor to high attrition
- Our training institutions do not have the capacity to train enough health personnel to meet the high demand in our health facilities.

This situation has impacted negatively on our plans to scale up the delivery of primary and specialised health care to the citizens of Zambia. The problem has been compounded by the recent Government policy to remove user fees in the rural districts, which has positively increased access to health services, but has created huge demand on both human resources and commodities such as drugs. This is at a time when we are struggling to cope with an increasing burden of ill health due to HIV/AIDS, which has a prevalence rate of 16% in the adult population.

In order to address the human resources crisis facing the health sector in Zambia, the Ministry of Health has developed and costed a five year Human Resources for Health Strategic Plan. Among the key strategic areas of focus in the plan is the development and harnessing of partnerships between foreign institutions and the health facilities in Zambia. We have identified facilities in the UK NHS that are strategically positioned to contribute to the capacity and development of our health system primarily through:

- Training in teaching, research, administrative support services, management and leadership
- Teaching clinical and other skills to doctors, nurses, paramedics and undergraduates
- Service planning and design
- Some targeted support through equipment and learning materials.

Not all partnerships are successful. Some disappear quickly, others have very limited effects. Some, however, have very real benefits – in terms of skill transfer, services and staff support and, albeit harder to measure, motivation and a sense of solidarity and emotional support.

There is need for research worldwide on what partnerships can achieve and on what makes an effective partnership. The UK with its partners in developing

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

countries will also need to work through how it wants to use partnerships and how to support them.

DFID, as the UK department responsible for development, has the principal responsibility for making strategic decisions about how much it wants to expand this activity and make use of the enormous reservoir of goodwill, expertise and experience available to it.

Its approach is to focus on relieving 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.

Against this background, UK health experience and expertise could be made available to support development 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. NICARE performs this function in Northern Ireland.

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. All these bodies can be supported by DH International, which was established to promote UK experience and expertise commercially.

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

Our 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, a hospital or a national organisation such as 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. The recommendations here provide a framework within which it could do so.

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 a country's plans, respond to their needs and enhance UK support.

There are already very many partnerships of different kinds in existence.

They have also been designed so as 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 (in the last chapter) or THET – to do so. Wherever possible, they are 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.

There will also need to be some additional resources provided. Many NHS organisations are already – in a planned or unplanned way – incurring costs as their organisations 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.

It is apparent that much of the current expenditure on development in the NHS is met by individuals – perhaps taking unpaid leave or their annual leave to work abroad – and by fundraising and charitable effort. Many simply volunteer on retirement or in a career break.

This will continue and may expand. Volunteering or raising resources in this way gives a great deal of local freedom to decide what to do. Fundraising can also build a sense of common purpose and commitment around a link – when staff as well as the organisation are committing time and money to it.

The THET survey, described earlier, identified the main problem areas as the ability to release staff to spend enough time on the link and the costs involved. In most cases, organisations were looking for a sum of around £10,000 to cover the basic costs of the link, with other costs met by the people involved and fund-raising.

Clearly, DFID cannot be expected to fund every link that may have grown up for personal or any number of ad hoc reasons; however, there is a case for its doing so where it and the country concerned see this as part of a local poverty reduction or health plan.

DFID's Africa Division has contracted with Crown Agents to set up a process for identifying what skills and expertise may be available across the whole UK public sector to assist in capacity building in Africa and to make some initial matches of skill with need.

This excellent initiative fits in very well with the proposal for a Global Health Partnership Centre described in the last chapter – which will be able to act as an

entry point to health for the Crown Agents – while Crown Agents will be able to take an overview of DFID's assessment of need. The partnership between the two can pave the way for a far more strategic approach to the use of UK experience and expertise.

Recommendation 8
I recommend that 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.***

Recommendation 9
I recommend that 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 which developing countries have supported as part of their poverty reduction or sector plans***
- ***Commission an evaluation of the potential of the impact of partnerships to understand what works, where and why.***

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8

Strengthening Health Systems

Summary

This chapter:

- Reviews the need to strengthen health systems in developing countries to ensure that they can serve the needs of their whole population
- Recognises that, while developing countries are creating health systems appropriate to their needs, the UK's experience of reforming the NHS can provide some helpful insights, particularly in those countries that have modelled their system on the NHS
- Suggests that developing countries may find it particularly relevant to draw on experience and expertise in the sub-systems and processes that make the whole system work effectively – via agencies such as the Health Protection Agency (HPA), the Healthcare Commission, the Health and Social Care Information Centre and the National Institute for Health and Clinical Excellence (NICE)
- Illustrates how UK public and private sector organisations can bring practical expertise to bear in dealing with systems for delivering services – such as the provision of drugs, the maintenance of equipment or the organisation and management of facilities
- Recommends ways of providing support.

The danger – in any system – is always that some people will be left out and inequalities will deepen

There are three main reasons why health systems need to be strengthened.

Firstly, many health services – whether they are immunisation programmes for children or providing care for pregnant women – depend on having a systematic way of getting services to the population. In other words, there needs to be some kind of infrastructure of staff and systems to identify and reach people. The danger – in any system – is always that some people will be left out and inequalities will deepen.

Secondly, there is rightly a great deal of attention given to the big killer diseases of malaria, HIV/AIDS and TB. However, experience has shown that there is little point in strengthening one part of a health system without paying attention to others. Simply strengthening the way that services are provided for AIDS patients, for example – without paying attention to the needs of the whole system – can lead to taking resources away from other health problems. So a well-resourced 'vertical' programme for AIDS can attract staff from other services, leaving the majority of patients in a worse position than before.

Thirdly, as is well recognised, people can suffer simultaneously from more than one disease or problem. In a South African study, for example, it was estimated that 35% of AIDS patients suffer from major depression.[1] The treatment of many diseases is often complicated by other problems, such as malnutrition. In all these cases the needs of patients must be seen in the round; and care and services provided systematically.

The ability to deliver the outcomes … of the multiplicity of health initiatives … requires a functional health system.

As Margaret Chan, Director-General of the World Health Organization (WHO), said in her address to the WHO Executive Board in January 2007: *"Here is the essence of our dilemma. We have a multiplicity of health initiatives focused on delivering outcomes. The ability to deliver the outcomes … of the multiplicity of health initiatives … requires a functional health system. Yet strengthening health systems is not the core purpose of these initiatives. We need a common approach to service delivery."*

Moreover, it is clear that a system-wide approach will be needed to achieve all the Millennium Development Goals.

These problems occur in any health system. In the UK, for example, we have to be careful to ensure that services reach everyone in our population, that an over-concentration on our big killers – cancer and coronary heart disease – doesn't distort other services and that we care for people in the round, looking after their depression as well as their cancer.

However, the problems in developing countries are enormously compounded by the lack of resources and infrastructure.

Strengthening health systems

It is no surprise therefore that a great deal of attention is being given to the need to strengthen health systems in developing countries.

The New Partnership for Africa's Development (NEPAD), the Commission for Africa, the World Bank, the WHO, and the Indian Government in its National Rural Health Mission all see this as an important part of their strategies.[2,3,4,5,6]

The UK, with the other G8 countries, has given the commitment to support health systems to ensure healthcare for all – free at the point of use, if that is what countries want.

The UK Government has also decided to *"commit at least half of all future UK direct support for developing countries to public services, to get children into school, improve healthcare, fight HIV/AIDS, provide more water and sanitation, and offer social protection; and agree ten-year commitments with developing countries to do this."*[7]

The WHO defines a health system very generally *"to include all those activities whose primary purpose is to promote, restore or maintain health"*.[5] This chapter uses a more detailed definition in order to identify those elements where UK experience and expertise may be relevant.

A health system is a means of improving health and getting services to a whole population:

- Which is made up of a number of different elements or sub-systems covering the whole range from health promotion and health protection to the provision of medicines and health services for individuals
- Where those parts are linked together within a common policy framework, with some shared values, some common rules and, where appropriate, the means of referring patients and sharing information between the different parts
- Which has an organisational structure and management processes that ensure care and services can be delivered.

This definition suggests it is worth looking at three areas where UK experience and expertise might be useful:

- The overall design of the system
- The parts that make it up and the way they are linked together
- Organisation and management.

The issues that need to be addressed are set out in the following prescription, by Professor Rachel Jenkins of the Mental Health WHO Collaborating Centre, of what is needed for a mental health service in a developing country. She stresses information, good practices, training, linkages, support and supervision, and resources.

The top priority is integration of mental health into primary healthcare. This entails:

1. Training the health workers and local trainers (basic training, post-basic training and continuing professional development)
2. Use of locally adapted good practice guidelines for assessment and management
3. Supply of essential medicines to the health centre and dispensary levels
4. Integration of mental health into health management information systems
5. Support and supervision from the district level, with district mental health professionals being able to access district transport to go to the health centres and dispensaries (often the district transport is monopolised by malaria and HIV)
6. Inclusion of mental health in district annual operation plans
7. Inclusion of mental health in national health sector strategic plans
8. Eventually inclusion of mental health in national social sector, police, prison, education, and employment sector plans – mental health is not just an issue for the health service but is also highly multisectoral in its ramifications.

... developing countries are beginning to create new models for health systems more suitable to their own needs than any that exist in developed countries.

Health system design

Many of the poorest countries in the world – and most where the Department for International Development (DFID) works directly – are Commonwealth countries that have systems modelled in some way on the 1948 NHS.

It is striking to see how many of them continue to follow what is happening with the reform of the NHS and to seek to learn from UK continuing experience. In meetings held to prepare *Global Health Partnerships*, many people – from Ghana, Jamaica and South Africa, for example – explicitly asked for contacts with people in the UK to discuss these changes. The memorandum of understanding with South Africa, described in the last chapter, provides for shared learning and for putting people in touch with their opposite numbers in the two countries.

This is not, however, a simple matter. Chapter 5 gave a brief outline of the different ways in which the health systems are developing in the different

countries of the UK. This illustrates some of the choices facing developing countries in thinking about the design of health systems, even when they are all based on the same original model. There are other models to consider – such as the American private insurance model or the Bismarckian social insurance model favoured in much of Europe.

This discussion serves as a warning about the danger of, consciously or otherwise, bringing assumptions about health systems from developed countries to developing ones.

It is even more important to recognise that developing countries are beginning to create new models for health systems more suitable to their own needs than any that exist in developed countries. There are emerging patterns which can be seen in different places where micro-credit is financing health costs, for example, and where new and different sorts of public/private partnerships are growing up.

The common history means that, while there is scope for the UK to work with developing countries in system design, it is important to be fully conscious of the potential pitfalls in doing so. Developing countries are inevitably going to be different, particularly in the context of a very large rural population, existing shortages of health staff and facilities, and different health needs.

However, there is also considerable scope for mutual learning, because all systems face some common issues.

... not a finished product but a process of engagement which might meet their needs ... an interest in the methodologies used, not the outcome as it applies to the UK.

The elements of the health system and their linkages

There are other areas where UK experience and expertise are even more directly relevant. These are in the 'sub-systems' and processes which together make the whole system work. These fall into three categories:

- Those concerned with public health and the methodologies of surveillance and outbreak management where, most notably, the HPA has a very significant international role
- Those that provide common services such as blood services, procurement and supplies
- Those that have some kind of system-wide management or regulatory function like the Healthcare Commission – which inspects for quality – or NICE – which assesses technology and provides guidelines.

In each of these cases, the actual outcomes of the processes are irrelevant to the developing country – the results of surveillance, the supplies procured or the decisions made by NICE are all only of interest in their own context. But the methodologies may be very relevant – how to conduct scientifically valid

surveillance, how to procure professionally and how to measure quality or decide which therapies to use are all highly relevant questions in every system. They will become even more relevant as more money is spent on health.

People said they most wanted help in particular parts of the system. The Health Minister for West Bengal, for example, wanted to know more about how the Healthcare Commission's approach might help him to assess the quality of services and how NICE might help in assessing what therapies to use. In both cases it was not the actual results of assessments he was interested in, but how their methodologies might be adapted to local circumstances.

Here, as elsewhere, people were interested in talking to and working with the actual people doing the job in the UK. They were not interested in *"a finished 'product' but in a 'process' of engagement to help meet their needs"*, in the words of Professor Janet Grant of the Open University.

There is a great deal of interest in health protection, the assessment of therapies and technologies, information management, the management of people, services and institutions, and the regulation of professions and services. The further areas of education and training and of information and communications technology and knowledge systems are picked up in Chapters 10, 11 and 12.

The following examples illustrate the types of experience and expertise available and the willingness of UK bodies to be involved in international development. In each case, the organisation has already been contacted for help directly from developing countries – in the case of NICE, very many times.

... developing guidelines for conditions ... that should never be relevant in the UK.

All of them respond on an ad hoc basis, being helpful where they can, but all of them are only funded to work in the UK. They could expand their role only in partnership with an internationally orientated body – perhaps a university – or if they were explicitly funded and staffed as part of a wider strategy to strengthen health systems.

NICE, which assesses the effectiveness and cost-effectiveness of technologies and therapies and produces clinical guidelines in England and Wales – and its Scottish equivalent, the Scottish Intercollegiate Guidelines Network (SIGN) – are genuinely world leaders. They are of interest in developing and developed countries alike, because they address some of the most crucial questions faced by any health system.

The WHO, for example, has asked NICE for assistance in developing guidelines for conditions, such as Dengue Fever, that should never be relevant in the UK.

Sir Michael Rawlins, Chair of NICE, suggests that NICE can play a role in education and training, in clinical guideline development and in research. He notes from his own experience in several countries that *"governments, in particular, are increasingly being provided with health technology assessments but lack the necessary skills to critically appraise them".*

Statistics give a voice to the poor.

Denise Lievesley

The Health and Social Care Information Centre has responsibility for the production of all the official statistics in health and, through its joint venture with Dr Foster, has the capacity to interrogate and interpret information at a local level. Both of these are activities essential to any health system and both are very weak in developing countries. All too often there is no data, and planning and evaluation take place in a vacuum.

There is now a substantial amount of work under way internationally with, for example, the Health Metrics Network. The Network is a global partnership, which aims to improve health and lives by strengthening and aligning health information systems around the world. The Ellison Institute at Harvard University has also been set up to provide key information on important benchmarks (spending, coverage of key services and interventions, efficiency and impact of current policies) to help governments, donors, foundations, non-governmental organisations (NGOs) and the private sector improve their own performance.

Denise Lievesley, Chief Executive of the Centre, makes a further very important point about how statistics can empower people by telling the truth about a situation. *"Statistics,"* she says passionately, *"give a voice to the poor."* She is scathing about the current situation and what she calls 'Safari research' and the vertical programmes that only look at a sub-set of information. She, too, would be keen to participate in partnerships with developing countries to improve matters and sees benefits for her organisation and staff from doing so.

There are a number of UK bodies involved in improving information provision, such as Partnerships in Health Information, based at Bournemouth University, offering links between UK-based individuals and organisations and those in developing countries. They emphasise the role that librarians in particular in developing countries can play in developing health.

The HPA, similarly, is much in demand as a world leader in public health, scientific expertise, research and emergency planning to protect people's health, and it maintains contacts worldwide as part of its surveillance of, and response to, public health threats. It, too, could provide support and assistance – crucially, training – if resourced to do so.

Pat Troop, Chief Executive of the HPA, says *"The four key areas of HPA expertise most widely sought internationally are advice and consultancy; research and development; training and teaching; and global alerting and international surveillance. However, the Agency is not funded for its international development work and our ability to respond and undertake much of our international work to date has been dependent on us securing funding from external sources. The contribution that the Agency can continue to make in improving capacity and expertise in health protection in the developing world is directly linked to our ability to secure such funding in the future."*

The Healthcare Commission was established to inspect the quality and value for money of both healthcare and public health; inform and equip patients with information; and, through these means, drive improvements in healthcare.

Its methodologies, too, are relevant to developing countries and, as the Chief Executive, Anna Walker, explains, it would be very pleased to be part of a 'process' to support system development in developing countries: *"From contacts, and our own assessment of the specific expertise and experience that we have developed over the last two and a half years, there are a number of areas where we could offer potential assistance to those from other healthcare systems. These include methods to establish and monitor national systems of standards of care, risk-based and proportionate approaches to regulation and inspection, patient and public involvement in regulatory approaches and investigation and reporting on serious service failures. The extent of any help will be dependent on resources being available for it."*

All of these organisations have an important role to play in the system, whether they are dealing with public or independent providers.

The involvement, integration and regulation of independent organisations and practitioners

The involvement, integration and regulation of independent organisations and practitioners present particular problems in any health system. This, too, is an area where the UK could work with developing countries, sharing experience and, at the same time, gaining deeper understanding of how to handle these issues in the UK.

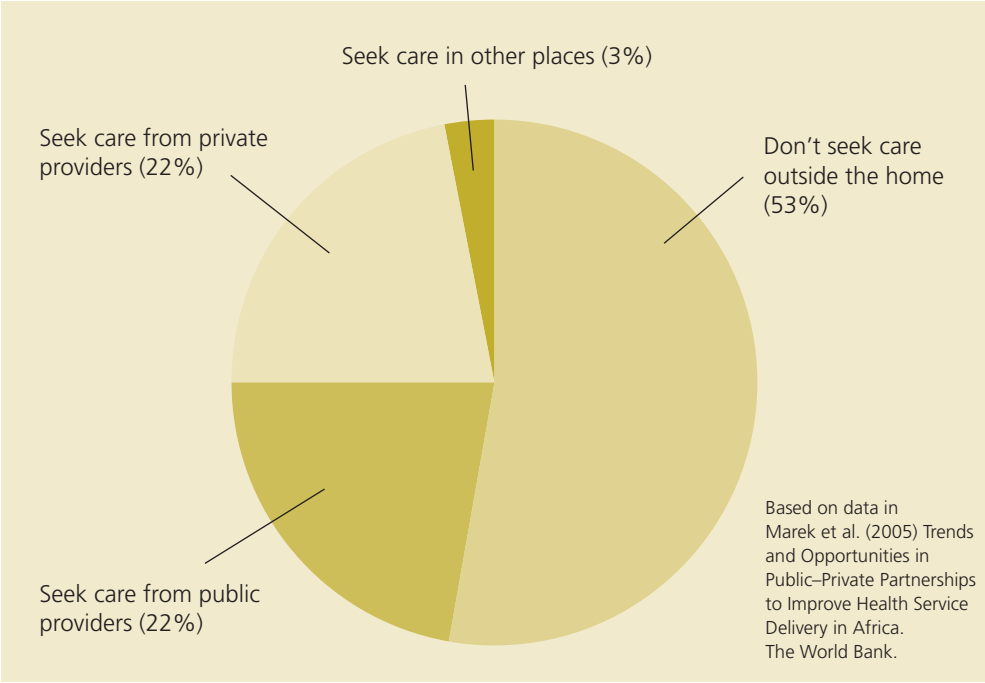
Private businesses and private practitioners, together with religious, charitable and other NGOs, are in fact the main providers in most developing countries. Some of them practise 'western scientific' medicine, while others have traditional and local approaches.

There are therefore very important considerations about how they work together and about how they are regulated.

Neelam Sekhri, in a World Economic Forum White Paper, *From Funding to Action: Strengthening Healthcare Systems in Sub-Saharan Africa,* provides an excellent analysis of healthcare funding and provision in Sub-Saharan Africa: *"A vibrant private health sector exists in Sub-Saharan Africa today. It is in fact large, diverse and unregulated. It is made up of independent medical practitioners, religious institutions, NGO-run facilities, pharmaceutical vendors, traditional healers, community workers, shopkeepers and others [p.17]."* [8]

She goes on to show how the poorest households mostly do not seek care outside their homes and – where they do – how they are just as likely to seek it from private as public providers (see Figure 4).

Figure 4: Where do the poor go for care?



Source: see Reference 8

The position in India and in other developing countries appears to be broadly similar, with a different balance of public–private mix, while in China great efforts are made to promote traditional Chinese medicine alongside 'western scientific' medicine.[9]

In an interview for *Global Health Partnerships*, Dr Ken Grant of HLSP argued that, as the independent sector is already the main provider in many places, it is very important to work to improve its quality and effectiveness and to provide some oversight and regulation. Others, in developing countries, told us of their concerns at the enormous variation in quality and the dangers of unregulated and unrestricted healthcare.

Governments have the responsibility to ensure that their populations receive the essential services they need, but not necessarily to provide these services themselves – the circumstances in different countries vary and there can be no blueprint for all circumstances. This means that they have very important roles – whoever provides the services – in developing the overall framework, in standards and in regulation.

Neelam Sekhri goes further and argues that ministries of health are too focused on running services and do not pay enough attention to regulation and *"... creating a positive environment for investment in health services and products and harnessing the talents of all partners towards the goal of better health [p.18]."*[8]

These words reflect the changes made recently in England. One of the principal reforms of the NHS in England – where I was Chief Executive for five years – was to move the government and NHS role towards setting the standards and specifying the services, while welcoming any providers – public, private or third sector – to provide the services, as long as they could meet those standards at NHS tariff prices.

Organisation and management

Issues around improving organisation and management featured strongly in all the discussions with people in developing countries. Chapter 2 gave examples of the problems people faced in making sure medicines reached the people they were intended for, that equipment was maintained and that staff were available, particularly in the most rural and remote areas.

These examples shows how fragile health systems are in developing countries – with little in the way of skilled people, and major problems of infrastructure, communication and transport. Even with our more sophisticated systems, developed countries have to be constantly vigilant in the purchase and distribution of, and accounting for, drugs. Keeping track of a shipment of medicines in Malawi's circumstances is very difficult.

... the absence of any means of turning good intent into practical action ...

They also reveal the gulf there is between planning at the national level and delivery on the ground. We saw good evidence of strategies and planning carried out well at the ministry and, equally, met caring staff doing their utmost locally. But, in many cases, people told us of the gaps in the middle – the absence of any means of turning good intent and good policy into practical action and delivery.

You can create standards, but how do you turn them into good practice locally? You can define responsibilities centrally, but how do you know they are delivered locally? You can buy medicines and equipment, but how do you know they are delivered?

This sort of separation between the front line and the headquarters exists in any organisation – and is one of the issues the NHS has worked to reduce over the years with greater decentralisation, improved information flows, better accountability and better training. But in developing countries, it is in a wholly different league – compounded by the lack of infrastructure and staff.

... wanted help from the people who were doing the same job in developed countries ...

The World Health Report for 2006, described in more detail in Chapter 9, shows that staffing overall in developing countries is very low. In Africa, for example, there are 2.3 health workers per 1,000 population compared with 18.9 in Europe and 24.8 in the Americas. Most importantly for this discussion, however, the proportion of staff working as support workers and management is even lower – at 17% in Africa compared with 31% in Europe and 43% in the Americas.[5]

The longer-term response to this, as described in Chapters 9 and 10, is to train and employ local people in organisation, logistics and management as well as in clinical skills. In the short term, however, there is an evident need for injections of expertise to help introduce systems and transfer knowledge.

Time and again, people said that they wanted help with practical aspects of delivery. The practical problems people faced were all about delivery. Several went further and said that they really wanted help from the people who were doing the same job in developed countries – not just from academics or professional consultants.

Pharmacists and Malawi

In Malawi, the Minister, the Honourable Marjorie Nguange, told us that what she really wanted was help with pharmacists. She explained that even though they bought quantities of drugs, many didn't arrive in the hospitals and clinics where they were needed. We knew this ourselves from our own observation. She also told us that she only had a handful of pharmacists in the country and wanted more.

The problems here were that the lack of any systems for monitoring and distributing drugs, for checking and for audit made it very easy for items to be stolen or lost. Since our meeting there are plans being developed for a major UK company, working with the Department of Health and NHS, to help set up the systems and provide direct practical support and training for the health system and the pharmacists. Their aim will be both to offer practical expertise and to help transfer skills and knowledge to the local people.

Support in this area can come from any number of NHS organisations and also from UK private sector organisations and education and research bodies. As I noted in Chapter 12, the Medical Research Council provides a great deal of the health infrastructure in The Gambia.

Conclusions and recommendations

This chapter has reviewed how UK experience and expertise in health can be applied strategically to help developing countries strengthen their health systems and reach the whole of their populations.

Some of this is already happening. Existing partnerships and links often involve working together on organisational and management issues. The South African memorandum, described in the last chapter, provides a framework for working on health systems. Many UK organisations respond to requests for information and assistance on an ad hoc basis.

However, there is no coordination of this, no learning about how best to provide this support, no dedicated resources and no systematic means of putting people and organisations, in developing countries and the UK in touch with each other.

The recommendations made in the last two chapters – about creating a stronger strategic partnership between DFID and the Department of Health, the creation of a Global Health Partnership Centre and the need to review and fund partnerships where developing countries want them – will all help.

Recommendation 10

In addition, I recommend that DFID should meet with representatives of the HPA, the Healthcare Commission, NICE, the Health and Social Care Information Centre, 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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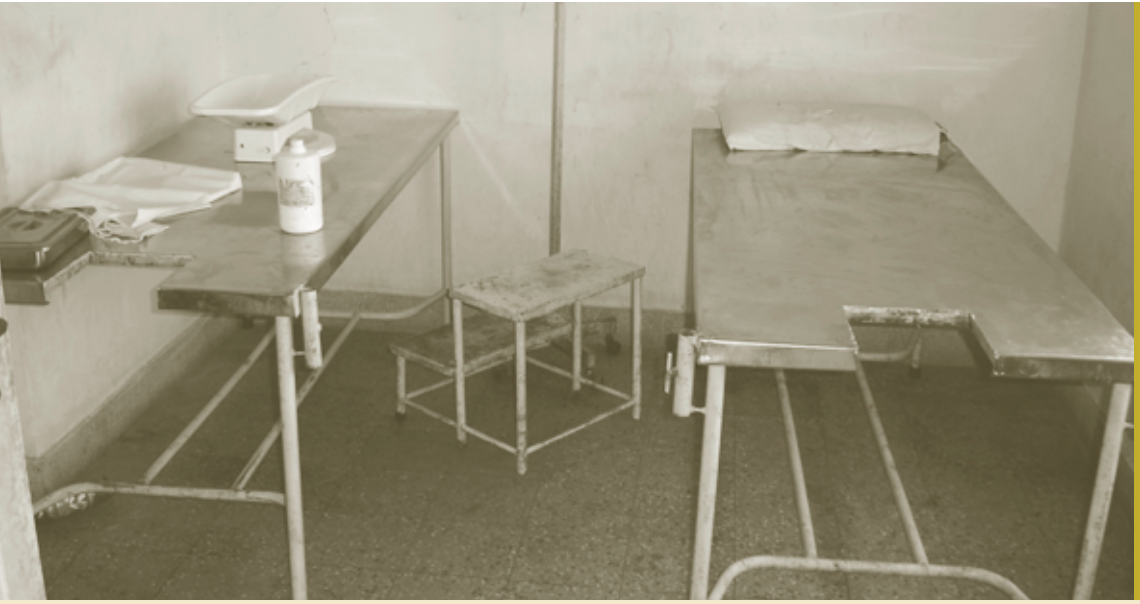


9

The Staffing Crisis

Summary

This chapter:

- Describes the crisis in staffing – with shortages of health workers particularly acute in the poorest countries of the world
- Reviews the migration of trained staff from developing countries, the way the UK has attempted to manage migration over the last few years and the consequences of recent decisions to curtail entry to the UK
- Considers how the UK experience of human resources management and professional development can contribute as part of a worldwide approach to improving the recruitment, employment and retention of staff
- Suggests ways of encouraging health workers to contribute to their countries of origin – and proposes the establishment of Service Scholarships, perhaps linked with the Commonwealth programme to support young leaders develop services over a five-year period
- Recommends that the UK should explicitly recognise its responsibility as the employer of a global workforce and seize the opportunity to help developing countries educate, train and employ their own staff.

At least 1.3 billion people around the world have no access to basic healthcare, and the reason for that is often a deficit of health workers.

WHO 2006

There is a critical shortfall in health workers which is particularly affecting the poorest countries.

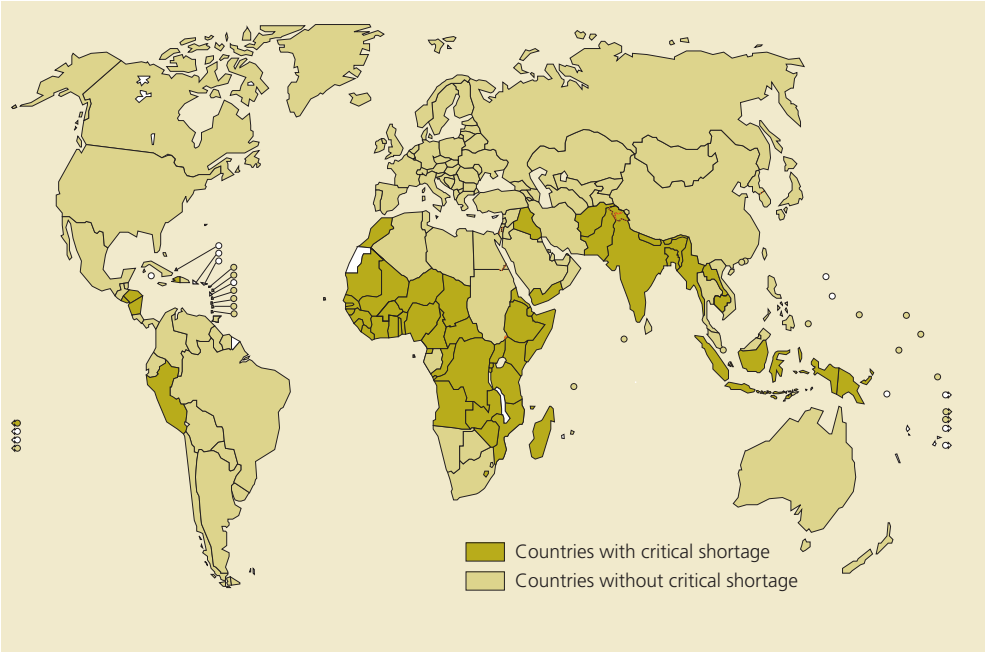
The World Health Organization (WHO) in its World Health Report for 2006, *Working Together for Health*,[1] has produced a definitive analysis which describes the extent of the problem and outlines and costs potential solutions.

The problem in developing countries arises for a number of interrelated reasons:

- Low expenditure on health leads to limited job opportunities – with unemployed health professionals in several countries – and scarce opportunities for professional development and training.
- Poor pay and conditions contribute to dissatisfaction and the inability of health workers to meet their personal needs for development and the physical needs of their immediate and extended families. This means that some countries have considerable numbers of trained health workers choosing to work in other sectors.
- Migration in search of better pay and opportunities – particularly among the most skilled, with the most easily transportable qualifications.

Figure 5 and Tables 6 and 7 show how the WHO Africa Region (Sub-Saharan Africa) and the South East Asia Region (including India, Bangladesh, Pakistan, Indonesia, Nepal and Thailand), for example, face the biggest problems. Some 57 countries have what the WHO defines as a critical shortage.

Figure 5: Countries with a critical shortage of health service providers (doctors, nurses and midwives)



Source: see Reference 1

Table 6 shows the numbers of staff in the different regions and the proportions who are health service providers as opposed to management and support workers. Sub-Saharan Africa stands out in both categories – with the shortage of managers and support workers contributing to the problems of organisation.

Table 6: Global health workforce by density

	Total health workforce		Health service providers		Health management and support workers	
WHO region	Number	Density (per 1,000 population)	Number	Percentage of total health workforce	Number	Percentage of total health workforce
Africa	1,640,000	2.3	1,360,000	83	280,000	17
Eastern Mediterranean	2,100,000	4.0	1,580,000	75	520,000	25
South East Asia	7,040,000	4.3	4,730,000	67	2,300,000	33
Western Pacific	10,070,000	5.8	7,810,000	78	2,260,000	23
Europe	16,630,000	18.9	11,540,000	69	5,090,000	31
Americas	21,740,000	24.8	12,460,000	57	9,280,000	43
World	**59,220,000**	**9.3**	**39,470,000**	**67**	**19,750,000**	**33**

Note: All data for latest available year. For countries where data on the number of health management and support workers were not available, estimates have been made based on regional averages for countries with complete data.

Source: see Reference 1

The WHO has estimated that worldwide there is a shortage of 4.3 million health workers, of whom 2.4 million are doctors, nurses and midwives. Table 7 gives the breakdown by WHO region.

Table 7: Estimated critical shortages of doctors, nurses and midwives, by WHO region

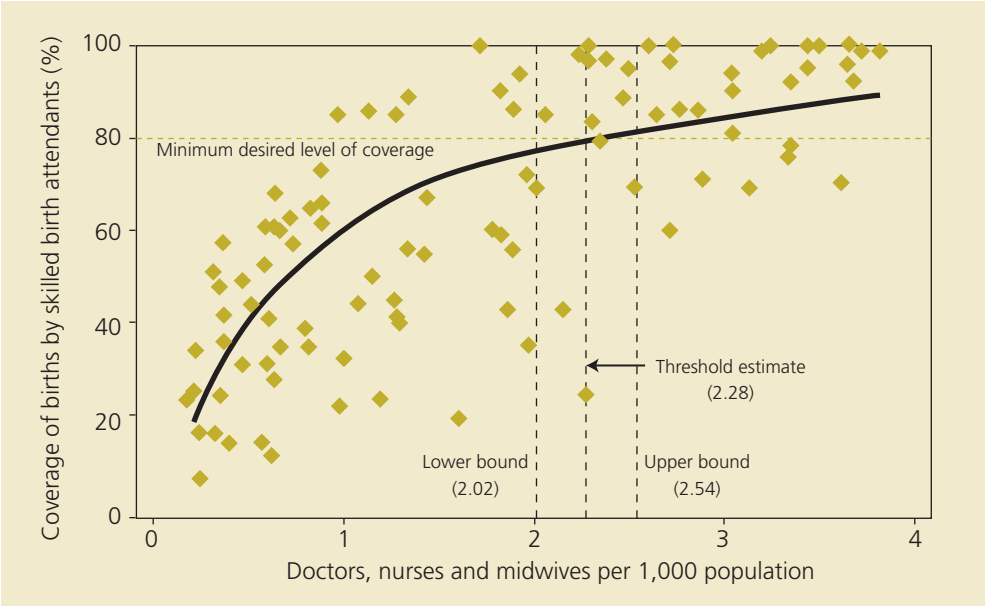
	Number of countries		In countries with shortages		
WHO region	Total	With shortages	Total stock	Estimated shortage	Percentage increase required
Africa	46	36	590,198	817,992	139
Americas	35	5	93,603	37,886	40
South East Asia	11	6	2,332,054	1,164,001	50
Europe	52	0	NA	NA	NA
Eastern Mediterranean	21	7	312,613	306,031	98
Western Pacific	27	3	27,260	32,560	119
World	**192**	**57**	**3,355,728**	**2,358,470**	**70**

Source: see Reference 1

These shortages matter because there is also clear evidence of a correlation between health indicators and the density of health workers, illustrated, for example, by the correlation between maternal death rate – devastatingly high in many developing countries – and the attendance by a skilled practitioner at a birth.

Figure 6 demonstrates how the number of skilled staff relates to attendance rates at births. The scatter on the graph also shows how countries with the same staffing levels can have very different percentages of births attended by a skilled person.

Figure 6: Population density of healthcare professionals required to ensure skilled attendance at births



Source: see Reference 1

This shows that it is not just numbers that matter – so do policy and practice. Countries, such as Sri Lanka, and states within countries, such as Kerala in India, achieve far better results than others with the same resources.

There appear to be three factors at work here:

- The number of health workers
- The distribution of health workers
- Wider policies.

In the case of Kerala, its high level of female literacy (87%); access to healthcare (for example 97% institutional deliveries); a good public distribution system, which provided essential food items at subsidised rates; political commitment in terms of higher allocation to health and education; good communication and transport; land reforms which helped reduce inequality in land and income; and availability of schools and hospitals in rural areas have been considered responsible for its good health.[2]

The World Health Report 2006 tells a compelling story. It advocates action on a whole range of human resources issues, including higher training levels, better employment practices and the management of migration.

Better organisation and better leadership can be crucial to the development of health systems. Well-run organisations can do more with fewer staff. The brief discussion of Kerala here also demonstrates the importance of taking action within the wider development and economic context of the country concerned.

Against this background there are a number of things the UK can do. This chapter discusses three of them:

- Helping developing countries manage migration and mitigate its effects
- Using UK experience and expertise to support human resources management
- Assisting migrants to the UK to contribute to health in the country of their origin.

A fourth, scaling up training and education for health workers, is addressed in the next chapter.

The scale and effects of migration

The global shortage of health workers means, in an increasingly global market, that there is considerable migration from one country to another. This deserves special attention here because many people – particularly from Commonwealth countries – have seen the UK as a destination of choice for education, training and career opportunities.

The UK, partly because of those Commonwealth links, has long been reliant on doctors from abroad – with 33% (69,0000) of UK doctors and 10% (65,000) of nurses receiving their initial training abroad.[3]

It is a popular destination, especially for doctors from South Asia. Membership or Fellowship of a UK Royal College is highly prized – with, for example, the Royal College of Obstetricians and Gynaecologists having more than half its membership overseas. However, many doctors have come to the UK for specialist training and return thereafter; typically, most leave within five years.

These proportions of professionals from abroad in the UK are among the highest in the world – lower than the proportions in New Zealand, but higher than the proportions in the USA where the actual numbers are much greater, with doctors at 27% (213,000) and nurses at 5% (99,000).[1]

A 'Policy Brief' from the WHO describes the global position and its impacts:

"The migration of skilled health workers has in the past decade become more complex, more global and of growing concern to countries that lose much-needed health workers. People have a right to move and seek the best employment they can get, but in preserving the right to move, some countries suffer disproportionately from the negative effects of migration. When significant numbers of doctors and nurses leave, the countries that financed their education end up unwillingly providing a kind of 'perverse subsidy' to the wealthier countries that receive them. Financial loss is not the most damaging outcome, however. If a country has a fragile health system, the loss of part of its workforce adds further strain and the impacts are most severe in rural and under served areas where emigration is often greatest."[4]

Not all migration is to developed countries. While doctors from Ghana and Zambia who go to the USA can earn up to 20 times as much as at home, junior doctors from those countries can earn five times more by moving to Lesotho, Botswana or South Africa.[5,6,7]

Nor is all migration for economic reasons. There are 'push' factors as well as 'pull'. Judith Oulton of the International Council of Nurses believes that nurses in particular are concerned about the working environment and their living conditions. This is also reported by Mireille Kingma in *Nurses on the Move*, an account of migration and the global health economy.[8]

Many people told me that having reasonable accommodation and schooling for their children were of fundamental importance. This is, of course, an even bigger problem in the poorest and most remote areas. These are themes explored in a number of studies by, among others, Jim Buchan, a UK specialist on migration.[9]

Migration and, subsequently, the impact of stopping immigration have both had serious effects.

It is also important to note that for some countries the migration – or export – of some health professionals is an important source of national income. Ghana, for example, receives remittances from abroad of 13% of its Gross Domestic Product. Health professionals contribute a portion of this.[10,11] The Philippines has a deliberate policy of training workers for export and other countries are considering this approach, although there is some debate over the impact of remittances on development, especially if they are not through formal channels.

The UK experience – codes of practice for international recruitment

In the late 1990s and the early 2000s the UK actively recruited staff from abroad as a short-term measure while it expanded its own training levels. It was very conscious of international concerns about recruitment and attempted to recruit 'ethically' on the basis of bilateral agreements with individual exporting countries.

It introduced international recruitment guidance in 1999 based on ethical principles and a code of practice for international recruitment in 2001 (updated in 2004).[12] These arrangements sought to stop active recruitment from developing countries unless there was a government to government agreement.

Within this framework, the Philippines and India felt they benefited more than they lost from international recruitment, particularly through the external remittances received. They were therefore content for international recruitment to take place in certain areas.

The UK took seriously the concerns expressed by the international community and worked to address them with individual countries. Additional support was given to the Caribbean and South Africa as countries with very particular issues.

These measures – together with greater self-sufficiency within the UK following increased investment in training, and other policies to address the UK's shortages in nursing (see box on page 123) – have had an effect, with registrations of trained nurses falling over the period as shown in Table 8.

Table 8: Nursing and midwifery registration: country of origin

Countries	2003/2004	2004/2005	2005/2006
India	3,073	3,690	3,551
Philippines	4,338	2,521	1,541
South Africa	1,689	933	378
Nigeria	511	466	381
West Indies	397	352	78
Zimbabwe	391	311	161
Ghana	354	272	154
Kenya	146	99	41
Malawi	64	52	41

Source: Nursing and Midwifery Council registration figures

A memorandum of understanding with South Africa was agreed to provide for the reciprocal exchange of skills and expertise, as described in Chapter 7. This has led to enhanced communication and cooperation between the two countries and significant opportunities for both of them.

The Department of Health's (DH's) international recruitment guidance, the code of practice and the memorandum of understanding have attracted a great deal of international attention. DH staff have been involved in discussions with the Organisation for Economic Co-operation and Development, the WHO, the Commonwealth and others.

The Commonwealth has, independently, drawn up its own code of practice. There are plans for a European Union (EU) one and Mary Robinson, the former

President of Ireland, has been asked by the Global Health Workforce Alliance to chair a task force reviewing migration with a view to finding ways to manage it in the interests of individuals and their home countries alike.

By 2006 the NHS was largely self-sufficient thanks to increased training. Additionally, the expansion of the EU has meant that health workers from East Europe are entitled to work here. As from March 2006 the UK largely closed its doors to health workers from other parts of the world. It has become probably the only large developed country which – in line with WHO policy – is now virtually self-sufficient in training.

This change in policy had been advocated, and was welcomed, by many. However, it has also had some negative consequences – it has ended some very long-standing training arrangements, individuals have seen their personal plans disrupted and levels of remittances have fallen, affecting income in developing countries. We were asked in several countries *"Why is the UK turning its back on us?"*.

Migration and, subsequently, the impact of stopping immigration have both had serious effects.

Responsibility and opportunity

Several people have argued passionately that the UK and other developed countries should pay 'compensation' for the staff working here on a sort of 'football transfer' system.

All the proposals to this effect seem enormously complicated and fail adequately to account for staff who, without any active recruitment, choose to migrate from one developing country to another – or from one developing country to a developed country and on to another – or who go home after a period abroad, where they may have benefited from additional training. Nor do they take account of UK staff working in developing countries.

I am not convinced that any mechanical scheme of this sort will be effective and would worry that it might generate bureaucracy, dispute and bad feeling,

It is clear, however, that the UK has benefited from staff trained abroad and is a genuinely global employer. Moreover, there will undoubtedly be times again in the future when the UK faces shortages – labour markets will be subject to peaks and troughs – and some UK training institutions are already expressing their concern about reductions in training numbers in the UK. The UK will therefore probably want in the longer term to see some continuing immigration for limited periods for both employment and training.

Against this background, as I recommend in the next chapter, I believe that the UK should take the opportunity to support the training and employment of

health workers in their own country. It should also, as a global employer, see itself as having a responsibility to do so.

Many developed countries would also welcome some of their staff being trained in the UK and having the opportunity to gain work experience – and to be able to send remittances home – provided this was done for limited periods of time with a requirement to return home. One of the ministers of health suggested to us just such an approach.

Such an approach would also be welcomed in the UK by teaching establishments and Royal Colleges. It would also be attractive to trainees and health workers if there were some possibilities for exchange – with UK people working and training abroad.

Recommendation 11
I recommend that 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***
- ***As part of this, creating exchange programmes for training and work experience for UK and developing countries' health workers.***

It is also important that developing countries do not evade any responsibility they may have for the 'push' factors that mean their staff may want to migrate. The World Health Report 2006 and the World Health Assembly resolution 57.19 put forward proposals which relate to the actions and responsibilities of both developing and developed countries.

The World Health Report 2006 calls for developing country leadership to cut waste, improve incentives, revitalise education and design national workforce strategies. It also outlines the need for global solidarity, including the pooling of expertise on workforce and education and training issues, implementation of ethical recruitment policies, and effective cooperation agreements to minimise any adverse consequences of international flows of workers.[1,13]

Human resources policies

The general picture presented elsewhere in *Global Health Partnerships* of high demand, scarce staff, limited other resources and poor organisation holds true for human resources management.

There are specific problems, too, such as workforce planning, staff management and staff motivation. There are many examples of staff trying to tackle problems beyond their capability and training, of poor people management and – for these and other reasons – astonishingly high absenteeism rates. Absence rates as high as 75% are reported in some areas.[14]

Dr Sambo, who takes a pan-African view as the WHO Regional Director for Africa, makes clear in a note prepared for this report, on page 29, that support with human resources management is absolutely fundamental. It is in many ways the critical factor in improving health in developing countries.

Developing countries are drawing up comprehensive human resources plans which highlight some of the problems and set out plans to address them. The Zambia Human Resources Plan, for example, is designed to cover the whole gamut of human resources: achieving a coordinated approach; having an increased number of trained and equitably distributed staff; improving the performance and productivity of health workers; and strengthening human resources planning, management and development.[15] The Public Health Foundation of India has also developed plans to increase human resources in health nationally.[16]

These are now being supported by a great deal of international effort.

- The UK, for example, has committed $99 million over six years to an ambitious and innovative Emergency Human Resources Programme in Malawi which, among other things, raises the pay of some groups of staff by more than 50% and improves working conditions. The UK has also helped CARRICOM (Caribbean) countries develop policies on human resources, improving working lives and 'managed' migration. There are many other international examples of these sorts of intervention as set out, for example, by the Capacity Project.[7]
- The Global Health Workforce Alliance was established, following the World Health Report 2006, to carry forward the recommendations for global action and to advocate for increased priority and funding to be given to human resources issues. It has an important role in supporting developing countries with the creation and implementation of ten-year human resources plans and spreading good practice.[17]
- The Council of the EU adopted an 'EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries' in April 2006 and made the commitment that *"The European Commission and its Member States will develop a coordinated, strong and visible EU response to the global call for action on Human Resources in Health Crisis [p. 10]"*.[18] In December 2006 this resulted in the adoption of a comprehensive programme of action to tackle health worker shortages.[19]

Against this policy background, UK experience and expertise are already playing a role in supporting policy and practice.

The 2006 conference, held as part of the South African memorandum of understanding, for example, focused on human resources and fostered further links between the two countries. The UK experience with its policy Improving Working Lives[20] and its experience with nurse recruitment were of particular interest to the South Africans. Brief summaries of both of these are given below.

The English experience in addressing shortages in health workers

The English experience over the last few years may offer some interesting pointers for the future in developing countries and the UK alike.

At the end of the 1990s the UK was faced with staff shortages – due in part to a reduction in training earlier in the decade – and the Government was determined to see the NHS expand and meet its own set of development goals (mainly the reduction in deaths from cancer and coronary heart disease and improvements in the speed of access to treatment). In the NHS Plan, published in 2000, it set out its ambition to employ a (net) increase of 10,000 more doctors and 30,000 more nurses.

It achieved this target for doctors and exceeded that for nurses – employing 74,524 more nurses by 2005 (compared with 1999). There were three principal means employed to do this:

- Increasing training
- Encouraging nurses to return to nursing
- Recruiting abroad.

Although the circumstances in the UK are very different, there may be lessons for developing countries here.

There is an obvious need to increase training.

There is also scope for encouraging trained nurses to return – perhaps after a break to have children. In England we encouraged this by introducing more 'family friendly' hours (so a returning nurse did not necessarily have to work nights, for example), allowing more part-time working and, crucially, setting up 'return to work' courses. In many countries there are large numbers of trained nurses not working as nurses – the Nurse Advisor to the Indian Government, for example, told us that only about 40% of trained nurses in India were actually working as nurses.

We also recruited from abroad, to address the shortage in the short term within the framework of the DH's international recruitment guidance.

Improving Working Lives

The *Improving Working Lives Standard*[20] sets a model of good human resources (HR) practice against which NHS employers and their staff can measure the organisation's HR management and against which NHS employers will be kite-marked. NHS organisations have been required to achieve accreditation against the Standard since April 2003, demonstrating that they are improving the working lives of staff.

Improving Working Lives is essentially about focusing on staff and the recruitment and retention of them. The measures and mechanisms needed to do this will differ between countries, but building a strategy to address these issues is a common, core requirement of any effective HR strategy.[20]

This experience can be brought to bear in a number of ways, through:

- Agreements to share good practice and learning at government level – the South African and Malawi examples
- Partnerships between institutions, where support with human resources is already sometimes a key component
- Individual secondments or placements of volunteers with organisations or ministries.

Here, as elsewhere, human resources management and policies must reflect the needs of the individual country and their planned mixes of staff. Different aspects of the UK experience will be relevant in different countries. There is considerable interest, for example, in many developing countries in the systematic approach to building public health capacity and capability in the UK.

Staffing and skill mix

The Zambia Human Resources Plan mentioned above, in common with others, describes the mix of skills needed to serve its population. In Zambia, as in many other developing countries, there are locally trained community health workers, clinical officers and others who don't fit into the traditional – and internationally regulated – categories of nurse, doctor and so on.

There is no doubt that these groups of workers – whether their focus is on public health, clinical interventions or other aspects of health care – must form the bulk of health workers in any developing countries. They will also be the main focus of the efforts to scale up training described in the next chapter.

The actual skill mix and training requirements will need to be determined in and by the country itself with regard to its needs, circumstances and resources.

Nevertheless, every country has a core role for nurses and midwives and they all recognise that these are pivotal to the provision of the quality of care. Indeed in most countries they are the largest group of healthcare professional. In some areas they are the only professionals available.

We have met with the nursing associations of South Africa and India and with the Royal College of Nurses in the UK and the International Council of Nurses. They have told me about some of the impressive things that nurses, midwives and their associations – reaching across the globe – have been able to do in building networks, sharing knowledge, teaching, learning and motivating each other.

They have also told me, not surprisingly, of the lowly status that nurses and midwives too often have, of their powerlessness and their lack of a voice. This may in some cases be at least partly due to these being mainly female professions.

More surprisingly, perhaps, I have heard from ministers in both Asia and Africa that they agree with some of these sentiments and are particularly interested in extending nurses' roles and in how nurse practitioners might work in their countries, particularly in primary care. This extension of roles is supported by research findings.[1]

There appears to be real scope here for the UK to play a significant role, alongside other developed countries, in developing nursing and midwifery as part of the strengthening of health systems more generally. I have heard requests for help with registration and training and, perhaps most importantly, for developing leadership and influence.

Senior UK leaders, such as the Chief Nursing Officers and senior nursing staff, play an important role internationally in promoting and developing nursing practice. The Nursing and Midwifery Council, the Royal Colleges of both Nursing and Midwives and the Commonwealth Steering Committee for Nursing and Midwifery, as well as senior nurses in positions of authority, all appear to be willing to play their part.

As importantly, the UK can respond to requests for training and education in a situation where too few nurses are trained. India, for example, trains 35,000 nurses and 25,000 doctors a year, while in the UK, with just 5% of the population, 23,000 nurses and 8,000 doctors entered training in 2005/6.[21]

Some of the same considerations apply to doctors in developing countries – and the UK Royal Colleges and the British Medical Association play important roles in providing support to individuals and organisations abroad.

However, doctors are generally in a much more powerful position and, in some countries, dominate all the levers of power. In West Bengal, for example, almost all administrative posts are held by clinical – as opposed to public health –

doctors; raising questions about the appropriate use of their scarce skills and the training provided to them for administration and management.

The position of nurses and midwives is, of course, intimately linked to the position of women in different societies. Despite an often less powerful position in society, many studies have shown the impact that educating and empowering women can have on health.[22] UK partnerships and programmes that engage with women in developing countries are likely to have a particular importance.

Supporting the diaspora to contribute to their country of origin

The counterpart to reducing migration to developed countries is considering how best to help migrants return permanently or temporarily to their countries of origin if they wish. Many already do so and make major contributions. In preparing *Global Health Partnerships* we met, for example, the head of a health service in Africa who was for many years a consultant in the UK, a minister who was a specialist in Chicago, another who has a UK PhD in community health, and many other leaders who trained and worked in the UK.

Africa Recruit advocates the return of migrants to offer their skills and assist in capacity building through working in Africa on a temporary, interim, consultancy or permanent basis. The UK Government also recognises that the positive economic, social and political connections that diasporas maintain with their countries of origin have the potential to be 'an engine of development'.[23]

Indeed many migrants to the UK do already make a contribution to their home countries through, for example, as described in Chapter 7, initiating partnerships or returning to provide specific services.

Many organisations have called for the UK to initiate a programme to assist such return of skills and experience to their home countries. Zimbabwe Futures, for example, has advocated the need to be prepared – once a suitable political opportunity presents itself – to enable Zimbabwean health professionals based in the UK to lead a revival of health services in their country of origin.[24]

The UK Government has made a commitment to explore opportunities for health workers to return from the UK to their own countries, for extended periods, to help improve health services.[25]

The Commons Select Committee has recommended that *"the Department for International Development (DFID) and relevant departments should examine, alongside diaspora organisations, whether there are initiatives they could take to encourage the temporary return of migrants to their home countries"*.[26]

This is a complicated area. Many migrants may not want to return, for a whole range of political and personal reasons, including salaries, working conditions, career development opportunities and other incentives. They may not be welcomed back – I have heard of considerable resentment towards returning migrants, particularly if they expect – or get – better jobs as a result of training gained overseas.

Nevertheless, there are things that the UK can do which are well worth serious consideration.

It would be possible to create a scheme, on a regionally or nationally organised basis, where people could be released for agreed periods and their posts 'back-filled' on a temporary basis through the recruitment of additional UK staff. This looks very complicated and would only be worth doing if there were likely to be real demand from individuals and real commitment from the developing countries to make good use of them.

Secondly – and more hopefully – I believe NHS organisations could build on the work they are already doing to make links with institutions in developing countries. Several of these, as described in Chapter 7, have developed because of community or personal links with a developing country. The links between Barnet, Enfield and Haringey Mental Health NHS Trust and various organisations in Sierra Leone is a case in point.

Such partnerships could provide the framework within which individuals could be granted – at the discretion of their employer – special leave to return to work for a period in their country of origin. More generally, through the link, individuals could find a variety of different ways of contributing to their homeland. The Tropical Health and Education Trust (THET) should include such contribution within its good practice guidance. DFID should see it as an important aspect of its support for partnerships and consider whether direct funding should be provided for this aspect.

Thirdly, I think this could be turned into a very important opportunity to support future health leaders in developing countries by creating a new scheme for UK or NHS Service Scholars or extending an existing scheme such as the Commonwealth Scholarships and Fellowships Plan (CSFP). The Commonwealth Scholarship Commission, which already administers over £16 million worth of awards, including the CSFP, is well placed to oversee such a scheme.

Such a scheme might be modelled on the Wellcome Research Fellowship Scheme and involve offering five years of funding to young people of potential – resident in the UK or in their countries of origin – who apply to do five years of service development in their own country.

This might involve, for example, working to develop maternity – or perhaps pharmacy – services in a region of the country. Each NHS Scholar would receive support in their own and their service's development from a UK institution and

from one in their own country. The NHS Scholars as a whole would be brought together from time to time to share and learn.

Provided there were enough in each of a number of countries – say ten at a time in ten countries – these Scholars could together over time form a force for major change and sustainable improvement. They could also work with other leadership scholars on programmes supported by other funders.

Recommendation 12
I recommend that the UK assist migrants from developing countries in the UK 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 scheme such as the Commonwealth Scholarships 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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10

Scaling Up the Education and Training of Health Workers in Developing Countries

Summary

This chapter:

- Looks at what scaling up education and training for health workers would mean in practice – and discusses the related questions of whether trained workers will find employment in their own country or whether they will simply emigrate, adding to the 'brain drain'
- Considers the range of workers to be educated, trained and employed and the likely costs – and recognises that funders and governments in developed and developing countries alike will need to be convinced that there are practical ways to scale up training and education
- Shows that scaling up will not just mean expanding current facilities and doing more of the same activities – and that there is a pressing need for more research and evaluation to assess what works and how to spread best practice
- Describes some of the existing activity and approaches to education and training – and notes the development of international and national partnerships which could support scale-up
- Argues that the UK should support international efforts to scale up education and training – and prepare to play its part by developing plans and reviewing how to deal with potential problems around immigration for trainees and the lack of incentives for education providers.

The last chapter argued that the UK – and developed countries more generally – have both a responsibility and the opportunity to support the education and training of health workers in developing countries.

This chapter looks at how education and training could be scaled up in practice to meet the Millennium Development Goals (MDGs).

It considers what types of health workers are needed to improve the health of the population and discusses the three related and very practical questions of:

- Will trained health workers find employment in their own countries?
- Will they stay – or will they emigrate?
- How could education and training be scaled up practically, cost effectively and sustainably?

These are current and very complex questions. They need to be addressed internationally in an organised and rigorous way – and with a great deal of urgency – if the MDGs are to be achieved.

This chapter sketches out the main trends and issues and proposes ways in which the UK can contribute.

The current situation

The current situation is both difficult and hopeful.

Far too few health workers are being trained to meet the needs of developing countries; many of those who are trained subsequently emigrate, and many who stay cannot find employment in health.[1]

These problems are compounded by the fact that there is very little continuing education and training available for those who are employed.

Too little money is spent on health; and many developing countries don't achieve the expenditure level of $34 per person per year needed to provide the essential healthcare package, recommended in *Macroeconomics and Health: Investing in Health for Economic Development* in 2001.[2]

This has been accompanied in Sub-Saharan Africa by the running down over the years of universities and medical schools – once prominent university medical schools like Makerere in Uganda are now shadows of their former selves – and the closing of nursing schools in several countries.

There are signs of change, however, and the recent emphasis on the health workforce, so effectively exemplified by *Working Together for Health*, the *World Health Report 2006*[1] and the 2006 World Health Assembly resolution on rapid scaling up of health workforce production,[3] is reinforcing these changes.

President Mbeki of South Africa has spoken powerfully of the need to reverse the decline of the African university and how: *"whether we cannot begin, once more, to deploy the available collective wisdom and capacity of our people for the development of our countries"*.[4]

In India, a powerful consortium, with the support of the Government, has established the Public Health Foundation of India to educate and train health workers in public health to meet the needs of the country in *"ways appropriate for India"* and, inter alia, to learn lessons for other developing countries.[5]

The UK Government has made a commitment to help developing countries in Africa solve their health staffing crises by training professional workers such as doctors, nurses, managers, pharmacists and other support staff, including support to higher education.

But there are obstacles to address if we are to play a significant role. Recent changes have meant it is harder for trainees and students from developing countries to come to the UK for education, training and work experience in healthcare.

... these goals can only be achieved with a massive increase in health workers as part of the overall health plans in each country.

In addition, UK universities are not generally incentivised to deliver education and training for poor countries and students – and the excellent work that is going on is mostly due to the passion and enthusiasm of individuals, rather than mainstream academic activity.

There is nevertheless an enormous amount of education and training underway – both internationally and in the UK – as the examples given in *Global Health Partnerships* illustrate.

Education, training and employment

The most powerful reasons for hope, however, are the international commitment to achieve the MDGs and the G8's commitment in 2005 to support the provision of basic services in health and to provide more funding to do so.[6]

The *World Health Report 2006* has helped show that these goals can only be achieved with a massive increase in health workers as part of the overall health plans in each country. This requires both increased employment and training and better retention of staff.

The outline of this argument – that achieving the MDGs requires more expenditure on health, and that a significant part of this needs to be spent urgently on staff training, employment and retention – appears to be broadly accepted internationally.

This argument and these commitments mean that in principle there should in future be additional funding available to meet some, but not all, of the training and employment needs.

Some governments and funders are indeed already focusing on education and training. Ethiopia, with support from USAID, has increased the training of local community health workers ten-fold in a year; Malawi, with support from the UK, is re-establishing pharmacist training and increasing medical student numbers.

However, there is, as yet, no agreement about how to do this internationally on a sufficiently large scale to make a difference to the MDGs – what sorts of health workers are needed, how scale-up could be achieved in practice and how training and employment could actually be funded in tandem.

There also needs to be a great deal more work done to determine the necessary scale-up of funding. The currently available estimates show the size of the issue but are insufficient for anything but the most broad-brush planning.

Working Together for Health estimates that to train enough workers to meet the total shortfall of health workers in the average country would cost $136 million each year over a ten-year period or, if scale-up were slower, $88 million over a 20-year period. The costs of employing the trained staff will be at least as much again.

These estimates are very sensitive to the assumptions used. They are based on the assumptions that doctors, nurses and midwives are trained with no substitution from less trained – and cheaper – staff and that there are no productivity improvements in either training or service delivery. They also seek to address the total shortfall in staff and are not calculated on the – presumably less demanding – basis of achieving the MDGs.

They show, nevertheless, the scale of the funding to be found and the urgency of working through imaginative and cost-effective solutions to all the immediate questions – what staff are needed to meet the MDGs? What mix of skills are required? How can they be trained and deployed? And how do growth in staff and improvement in health need to be phased to match the funding available?

They also raise the questions about how health and training will be funded in each country – with what mix of aid money and government resources and whether training fees and patient co-payments will be used.

Plans for training and employment will depend on funders and governments in developed and developing countries alike being convinced that trained workers will stay in the country and that there are practical ways to scale up training and education and to pay for it.

Helping trained health workers to stay in the country

Past experience has shown that many qualified health workers will leave their country of origin to better themselves and their families or to escape difficult and dangerous conditions – and that developed countries often, but not always, welcome them.

There appear to be three broad ways of tackling this – helping reduce migration and mitigate its effects.

The first is to create improved employment conditions and opportunities in the country, so as to reduce the factors 'pushing' people to emigrate and to encourage their return.

This requires – as is happening in many countries – re-thinking the whole human resources policy, the conditions of employment, the pay, the working and living environment, the development opportunities, the training and the incentive structures. This – and the potential UK support for this – was discussed in the last chapter.

The second approach is managing migration through international codes of practice and bilateral agreements.

This may lead to different policies being adopted in different countries – with some choosing to train a proportion of their health workers explicitly for 'export' so as to receive remittances in hard currency from abroad, while others concentrate on retaining their staff.

The third approach is to train health workers to meet local needs with local qualifications that are not recognised internationally – and which do not help staff to emigrate.

This already happens to a great extent in practice simply because the workers who are needed are local and skilled only in certain areas of knowledge and practice. Zambia is one of many countries which has explicitly adopted this policy with part of its workforce: referring to new groups of staff, its *Human Resources for Health Strategic Plan* says: *"Health workers with this type of qualification would be able to move through a defined career structure but would not be marketable outside Zambia [p.16]."*[7]

This third approach will not work with the most highly qualified professionals – the nurses, midwives, scientists and doctors who will still be needed in any society aiming for higher standards. In their case some combination of improved conditions, incentives, possible access to training and experience abroad will need to be employed alongside the international agreements.

Scaling up practically, cost effectively and sustainably

Scaling up needs to be seen in the context of each country – its circumstances, infrastructure and ability, with the help of donors, to fund development.

The MDGs and G8 commitments themselves help define the sort of health workers who will be needed – those who can contribute most effectively to reducing maternal and child death, tackling HIV/AIDS, tuberculosis and malaria and providing basic services to the whole population.

This is not one group of health workers but many, working together and with their fellow citizens.

Taking the MDGs and the G8 committments as the focus, the needs for education and training fall into:

- Health education for and empowerment of family members, especially women – the bedrock of care – with 50% of the poorest families not seeking help outside the home
- Work with traditional health workers – fully integrated in China, involved in different ways, or not at all, elsewhere
- Support and development for community workers – such as Malawi's Health Surveillance Assistants or Pakistan's Lady Health Workers – doing variously a mix of public health and primary interventions
- Training 'mid-level workers' – including in much of Africa, the clinical officers who undertake many clinical tasks, may run whole hospitals and undertake operations, including Caesareans
- Educating the qualified professionals – nurses, midwives, doctors, scientists, dentists, therapists, radiographers and others – who will work in primary care and hospitals.

The largest numbers are in the first few categories, but there remains a need for sufficient numbers in the latter ones to ensure adequate supervision and training for the whole system, as well as to provide direct care for the most clinically complex cases. The precise 'skill mix' needed in any country will depend on its own circumstances and its ambitions for the health of its people.

This description emphasises that public health and health education for the public – including clean water, safe disposal of sewage, contraception, the importance of immunisation, the use of bed nets, nutrition and the treatment of minor ailments before they become major – must be at the heart of health policy.

It also shows how different the education and training needs are from those of the UK and other developed countries. There is a very strong emphasis on public health rather than clinical medicine. This is reflected, for example, in the plans of

the Public Health Foundation of India. The differences between developed and developing countries are also revealed in the Foundation's intention to develop public health in ways appropriate to India – and to other developing countries.

One other aspect, which came out very strongly from discussions and visits in developing countries, is the need for training and education in organisation and management. Developing countries, particularly in Africa, have a very thin management infrastructure and a desperate need for good logistics, organisation and financial management.

The actual competencies required by health workers at all levels in the developing world will necessarily be dependent on the needs of the population and the circumstances in which they practice. Similarly, methods of delivering education and training will need to be geared to the circumstances of developing countries.

Scaling up provision quickly and cost effectively cannot simply be about expanding existing institutions and programmes – the numbers are too large and the costs too high.

Scaling up provision quickly and cost effectively cannot simply be about expanding existing institutions and programmes – the numbers are too large and the costs too high.

The existing provision in Sub-Saharan Africa, for example, has the capacity to train 4,000 doctors and 12,000 nurses and midwives a year;[8] the numbers trained abroad and returning home are far fewer. These figures compare with the estimated current shortfall for these professions of a combined total of 818,000.[1]

Scaling up will require investment in existing infrastructure and some growth in training abroad, but will also need new institutions, new facilities and the ability – via distance learning and the innovative use of digital technology – to educate and train people in a variety of locations in their home country.

It will also require the very careful assessment and comparison of costs between the different methods of delivery.

Research and evaluation – finding the right models for delivery

There is an absolutely crucial role here for research, for evaluation of what works in practice – in the design of work roles and the development of education and training – and for the assessment of costs and cost effectiveness.

There is already a great deal of research about the impact of different types of health worker – some of it cited in the *World Health Report 2006* – with important lessons learned about what community health workers can and cannot do and where more highly trained professionals may be more effective and cost effective. One of the roles of the Global Health Workforce Alliance, created following the *World Health Report*, is to bring this all together, analyse it, disseminate understanding and best practice, and estimate costs.

There is, as yet, less evidence available about education and training curricula, programmes and methods of delivery, and a pressing need to understand what is most effective and cost effective. There are a number of examples of organisations and groups seeking to learn and evaluate – such as the UK's Best Practice Network on Global Health Education – but these need to be expanded and developed to meet the needs of a large scaling up of activity.

There is even less evidence about what works in terms of continuing education and training – both to meet new needs and use new therapies and to refresh and retain existing knowledge. Sadly, there is a great deal of anecdotal evidence of declining standards and decaying knowledge over time. Possible new ways of maintaining and developing knowledge are described in Chapter 12.

Work already underway in many developing countries can provide models for what works and what can be expanded – with the Ethiopian and Malawian examples given here only two examples from many. Understanding and learning the lessons from these live examples from developing countries is essential in developing plans for any scale-up.

Some of the work already done by UK organisations also provides some pointers for what a major scaling up of provision might involve. Importantly, scaling up will almost certainly involve all these approaches and more; there is no single solution.

Existing approaches which could be harnessed in scale-up include:

- Continuing and expanding training and work experience in the UK and providing opportunities for exchanges between developing countries and UK trainees – through universities, Royal Colleges and NHS organisations
- Building more institutional links with education as a prime focus – such as that where Addenbrooke's is providing support to the Princess Marina to develop as Botswana's only Teaching Hospital
- Responding to specific requests – such as those we received for 'adjunct faculty' at the University of Ghana College of Health Sciences to expand its capacity or for developing faculty for the Public Health Foundation of India
- Distance learning, provided, for example, by the University of Cardiff (see box) or the Open University (OU)
- The development of local capacity and networks for learning through the OU (see box)
- The creation of the International Virtual Medical School (IVIMEDS) and Nursing School (IVINURS) by a consortium of UK and other universities, led from Dundee. IVIMEDS supports distance learning in medicine with an innovative range of products and an electronic library of images, videos and recordings. It has set up a Foundation to deliver similar products to meet the needs of developing countries.

Cardiff University – distance learning since 1989

Cardiff provides e-based distance learning courses in dermatology, palliative care, pharmacology and therapeutics, geriatric medicine and pain relief.

The programme for palliative care, for example, has a strong international flavour, attracting students from more than 40 countries. Courses are tailored to studying and learning in the student's own clinical area and profession – with case studies based on the patients that students are currently looking after and course work reflecting their own working environment.

Professor Illora Finlay, the programme originator, recognises that *"life events mean that sometimes students do not finish their chosen course"*. Arrangements can be made for diploma students to leave with a certificate and be eligible for later re-entry.

The scheme currently has six scholarships for Indian students and has applied for 20 more for Africa.

The Open University – supporting educators and building networks

The OU has an impressive range of programmes designed to meet the needs of developing countries in health and social care.

The OU approach is to support its health projects with experienced development people who can ensure the projects are introduced appropriately and with due regard to local limitations. In this way they are able to support countries with better access to good quality educational materials, collaborate to improve and update pedagogy and engage in research partnerships to build capacity in higher education.

One successful example is the development of an HIV/AIDS programme for clinicians based in Vellore in India. The initial teaching and organisation was provided by the OU – at the invitation of the local college – but as the programme has developed, course graduates are able to take it on to others, elsewhere in India. There is now a thriving network of clinicians who are both spreading the learning across their country but also able to be kept constantly updated through the network. The OU has sown and nurtured the development of a continuing and self-sustaining learning network.

The OU approach, their experience and resources means they are well placed to contribute to a major scaling-up of education globally.

The Primary Trauma Care Foundation

The Primary Trauma Care (PTC) Foundation, based in Oxford, has been working with interested Oxford Radcliffe NHS employers and NHS staff nationally to train doctors in the management of the severely injured patient in developing countries, and in areas with limited healthcare facilities.

These programmes have been run in over 33 countries, and the PTC *Trauma Manual*, published by the World Health Organization, is translated into 11 languages. The PTC Foundation is working with the Ministry of Health in China to establish training programmes in 700 teaching hospitals, over a three-year period.

Many of these examples illustrate innovative ways of delivering education and training. The next two chapters discuss the potential of the digital revolution to assist in staff education as well as service provision and the evolution of knowledge management in the UK. Plans for scaling up education and training need to take account of these developments so as to reduce costs and waste and be better able to reach wider groups of health workers and lay people alike.

Any review of how to scale up needs to consider in detail the current role and the potential of the independent and commercial sectors to play a very significant part.

Many education providers are from the independent and commercial sectors – with a rapid growth of private education provision for health professionals in recent years.[1] Other commercial organisations, such as pharmaceutical companies, play an important role in aspects of continuing education within and alongside wider partnership projects.[9]

Curricula, quality control and accreditation

Quality control and accreditation need to be addressed alongside the development of programmes. Here again it is very important to ensure that standards are appropriate to the conditions of the developing country and not matched against the standards and much higher expenditure of the UK and other developed countries.

There are many examples of successful collaborations between developing and developed countries in developing curricula, setting out standards and developing methods of assessment for education and training. The UK Royal Colleges have played a particular role here in many countries with, for example, the Royal College of General Practitioners providing accreditation for family medicine education and training in collaboration with local organisations for almost the whole of South Asia. Membership of a UK Royal College is still a prized attribute, as mentioned earlier, in many parts of the world.

Professor Peter Walker, former Dean of the Faculty of Medicine in Ottawa, has sketched out the beginnings – but only the beginnings – of international definitions of competencies and the standardisation of accreditation. In an unpublished document he has attempted to draw together the core competencies of international – francophone and anglophone – medical education bodies.[10]

These approaches will need to be developed further to meet the needs of developing countries and to allow consistent standards to be applied as part of a global scaling-up of education and training.

Conclusions and recommendations

This brief review of education and training illustrates a little of what is already going on. The examples used here for the UK could have been matched by others from the USA or Canada, by those developed by France for the francophone countries, or by those developed collaboratively among the Portuguese speaking countries.

There are also a number of international partnerships ambitious to operate at a large scale and address the problem globally.

The Global Health Workforce Alliance, mentioned earlier, was set up in 2006 to carry forward the work outlined in *Working Together for Health*.[1,11] I have been privileged to chair a Task Force jointly with Stephen Mallinga, Minister for Health for Uganda, to look at scaling up education and training for health workers as part of its bigger agenda.

More recently, the World Bank has set up a programme to strengthen human resources and education and training through partnerships between developed and developing countries. It has initiated discussion around creating a West Africa health campus, with the involvement of institutions from Ghana, Sierra Leone, Liberia, the USA and the UK, and is building on existing partnerships in East and southern Africa.

Much of the current activity is excellent – there are many wonderful examples to cite from all parts of the world – and the initiatives from the Global Health Workforce Alliance and the World Bank are encouraging. But, as yet, none of this activity is impacting significantly on the problem of providing the necessary health workers in developing countries to deliver the MDGs and other health improvements.

As Francis Omaswa, Executive Director of the Global Health Workforce Alliance, says: *"The international community must urgently come together to mount a massive pre-service education and training effort that addresses the widespread global shortages of health workers that is experienced by most countries both poor and rich. It is these shortages that are the root cause of mal-distribution, migration and failure to reach MDGs."*

"The international community must urgently come together to mount a massive pre-service education and training effort that addresses the widespread global shortages of health workers ...."

Addressing the current shortage of 4.3 million health workers worldwide will require a three-part approach – similar to that adopted internationally for the Fast Track Initiative (FTI) in Education – which will build on current activity through:

- The creation by developing countries of detailed education and training plans for the health workforce – linked to their employment and wider human resources – which show how they will use the trained workers to deliver the MDGs
- The development of an international body of knowledge, best practice and continuing research about how to effect the necessary scaling-up of education and training in practice
- Agreement by the major funders – and by the developing countries themselves – to use a significant part of the planned new funding for health for the education, training and employment of health workers.

Through the Education for All FTI, partners help low-income countries to close gaps in policy, by providing support for country-led ten-year education plans; in local capacity, by providing technical assistance; in finance, by providing additional aid through budget support; and in data, to help track progress towards the education MDG. The FTI also aims to improve the effectiveness of aid by encouraging donors to work together and improve coordination and alignment of funds. The Global Health Workforce Alliance Task Force, described above, is considering whether a similar approach might be needed for the scaling-up of education and training of the health workforce.

There are also particular UK issues to address.

There has been a great deal of concern that, as described in the last chapter, changes in immigration practice have made it very difficult for students, trainees and those on work experience to come to the UK. The Home Office has responded by working with other departments and meeting health and education leaders.

As a result, some changes have been made which appear to have eased the situation by providing for UK organisations to be able to sponsor groups or individuals. However, there are still some concerns about the requirement to fund trainees at UK levels and other matters.

These arrangements need to be reviewed in practice with some suitable means of appeal involving Department of Health officials alongside those from the Home Office.

Universities have also been concerned that their whole incentive structure – focusing as it does on the Research Assessment Exercise and Advisory Committee on Clinical Excellence Awards – gives no recognition to their work in supporting developing countries and, indeed, militates against it.

They are also concerned that there are no dedicated funding streams for international development and health – although there is some funding available to support higher education partnerships with Africa more generally.

These issues clearly need to be addressed, but there are also a number of positive developments. The UK Government has already made a commitment to work with developing countries to back ten-year plans to improve health services, including ways of recruiting and training more doctors and nurses.[12] People attending meetings held in preparation for this report have stressed the opportunity for a much more organised approach to be taken in the UK. They revealed for the first time the extent of activity undertaken educationally – and the lack of coordination and communication between the UK organisations.

Universities UK, among others, has seen the opportunity for greater collaboration between UK providers and suggested the establishment of an 'observatory' to collate and share information. It has also described the need to provide a strategic framework for action – focused on what is needed in developing countries.

At the same time, a number of partnerships between UK organisations are being established to take forward education and training in developing countries.

The UK has a well-established reputation in education and training, a good track record and many international links; improved coordination, communication and partnership within the UK will help it make an even greater contribution internationally in the future.

In the last chapter I recommended that 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.

I also recommended that the UK should commit 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.

Recommendation 13
Here I recommend further that 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 which 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.***

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11

The Technological and Commercial Environment

Summary

This chapter:

- Discusses how we can help get health benefits from the innovation in information and communication technology (ICT) for developing countries – and, perhaps most importantly, how ICT can enable local entrepreneurs to improve health and health services themselves
- Describes some of the activity in telemedicine which is already underway – and identifies current limitations as well as future potential
- Suggests that this new technology and approaches are not yet being seen as central to international development – partly because it is still early in their development but partly because there needs to be more contact between people working in ICT and people working in development
- Recognises that economic growth is the greatest driver of development and that:
  - international agencies in developing countries are already working with commercial organisations in 'emerging markets' to provide investment in, for example, medicines, technology and infrastructure.
  - there needs to be a parallel emphasis on supporting entrepreneurial activity at the very local level, improving health as well as helping people out of poverty.

... knowledge and information will generate wealth and power ... the ICT-connected elite live such different lives from the poor.

We are only just beginning to understand the radical impact that digital technology and developments in science will have on all our futures.

Thomas Friedman in *The World is Flat*[1] has attempted to describe what this will be like in his 'brief history of the 21st century' when, as he says, technologies will converge to reinforce each other, our behaviours will change in response to the technology and, at the same time, 3 billion more people from India, China, Russia and South America will enter the world's economic system.

We will be living in a 'flat world' – fast moving, joined-up, without barriers; where knowledge and information will generate wealth and power.

The impact of these revolutions on the poorest developing countries and on the poor in all countries is even less well known and even less well understood. The threat to them, however, can easily be imagined, with these countries and their populations missing out on all the benefits of the 'flat world', becoming more powerless and being left even further behind in poverty.

We can already see some evidence of this growing inequality in developed countries, although it is perhaps at its starkest in India – where the ICT-connected elite live such different lives from the poor.

This chapter reviews the technological and commercial environment in order to ask two important questions:

- How can we help developing countries get the benefits for health and health services out of all this extraordinary innovation?
- How can ICT assist local entrepreneurs and support local creativity to improve health and health services themselves?

ICT and telemedicine

ICT and telemedicine are already beginning to have some impact in developing countries. They have been put to good use in many projects providing services, offering consultation, delivering education and improving management in developing countries over the last few years. (See the box on the next page for some UK-initiated examples.)

Governments and international organisations are increasingly active in developing strategies and plans both for creating the infrastructure necessary – often shared between many sectors and services – and for its use in improving health.

In 2005, the World Health Organization (WHO) adopted a resolution on eHealth, noting the potential impact that advances in information and communication technologies could have on healthcare delivery, public health and research, for example, and the cost-effectiveness of eHealth. This has formed a framework for a wide-ranging international work programme.[2,3] The European Union, working

with the African Union and the African Regional Economic Communities; the Commonwealth Business Council; the African Region of the WHO; and others, have also all been developing projects, adopting policies and agreeing recent strategies.[4,5]

The Indian President was explicit about ICT being both a wealth creator and a service improver when he said in an address to the nation in 2003: *"The mission of information and communication technology and related services is one of the wealth generators for the nation ... The benefits of ICT must reach all parts of the country through telemedicine, tele-education and e-governance."*[6]

The Indian national approach is reflected in the activities of its States. The West Bengal Government, for example, has specifically seen the relevance of telemedicine in its State, which has, with insufficient infrastructure, a large and dispersed population and low levels of training and education.[7]

Telemedicine – some practical UK-initiated examples

The Swinfen Charitable Trust has a panel of consultants from many countries, in a wide variety of specialties and sub-specialties, who give their advice, free of charge, via the internet to help their professional colleagues in difficult situations.

A high resolution digital camera is provided in the remote hospital and used to capture images of x-rays, skin conditions, MRI/ultrasounds scans, wounds, etc. The image, together with written patient information, is sent, attached to an email, to an automatic routing system and on to a consultant for advice.

The Trust already has telemedical links with institutions in more than 20 countries – and many requests for expansion. It is run and funded through the efforts of volunteers.

Partnerships in Information, and other organisations mentioned in earlier chapters, use digital links to support the use of technology as well as all the aspects of information management – helping local staff with public health surveillance and planning and managing resources.

Since 1998, **Computer Aid** has provided 70,000 refurbished computers to organisations in developing countries. It works with local partners – in health and education – to meet needs identified locally.

e-Learning at scale

There are many UK examples of ICT-enabled distance learning. Internationally there are now some very large schemes underway, which seem to offer the potential for still greater benefit.

An e-learning programme run by **The African Medical and Research Foundation** (AMREF) and supported by Accenture is delivering the education needed to upgrade Kenya's 26,000 nurses from 'enrolled' to 'registered' (diploma level) status.

AMREF estimates that relying on traditional methods, with instructor shortages, the task would take 100 years and cost $50 million. Their intention is to complete it in five years at a cost of $2.9 million.

Working within the limitations

In each of these examples, great efforts have been made to use technology that has been tested and known to be effective. As Roger Swinfen says: *"We are keeping it as simple as we can – gathering referrals at local centres and using the internet for email."* Each is operating within the bounds of what is already proven, but can be expanded as technology develops.

There are serious limitations. Broadband is still not widespread and is frequently of low density, suitable only for text and not images. Computers are not robust, maintenance is difficult, satellite expensive. In the health sector alone, the WHO has estimated that 50% of technology imported from developed countries is unused in developing countries simply because there has not been any training.[8]

An unpublished paper, prepared for the Global Health Workforce Alliance, has shown that where there are a wide variety of modalities for communication available – paper, phone, fax, video, email, discs and DVDs – there is still a tendency to make most use of the traditional means and least of the new.[9]

All of this means that, even as we plan for a changed world, we should not give up existing approaches based on books, paper and telephones (see box below).

The International Council of Nurses has a programme, sponsored by **Merck**, to distribute health libraries to remote areas and refugee camps. The WHO Blue Trunks serve a similar purpose.

Book Aid International works in 18 countries providing over half a million books and journals each year to libraries, hospitals, refugee camps and schools.

Because of the existing limitations, UK institutions such as the **British Medical Association (BMA)** International Department argue that it should continue to make available printed and other learning materials ... *"as the evidence shows that printed resources are still likely to have the most impact in low income countries"*.[10]

The potential for the future

Nevertheless, the potential of ICT for the future, as knowledge and experiences grows, appears to be enormous, with scope to:

- Improve surveillance, disease management and epidemiological research
- Deliver advice and services over a distance, through a variety of media and methods
- Help staff to learn, be updated and consult colleagues
- Assist with good clinical and administrative record keeping – keeping track of patients and their conditions and managing resources
- Provide public and patient education.

Perhaps most important of all, is the scope the technology gives for creativity ...

However, we are not yet at the point where its potential is anywhere near being realised, nor is it yet part of the mainstream of development thinking.

This is partly because the technology is still relatively new, there are real problems to address and there has been little evaluation or research about how it can most effectively be used.

It seems also to be partly due, however, to the fact that there appears to be little contact between people working in ICT and technology and those working in international development. They live in different worlds with very different perspectives.

Given the critical state of healthcare in developing countries – and the shortage of people and of money – a great deal would be gained from bringing the two groups together to use their expertise and experience jointly to understand the practical possibilities.

The biggest advantages are in the way this technology can reach almost anywhere – there is a less need for fixed infrastructure – with a lower cost, reduction in the number of processes and a higher speed of transaction.

Local entrepreneurs and local creativity

Perhaps most important of all is the scope the technology gives for creativity – for people to use it in ways never anticipated by its designers. In the developed world we have blogs, facebook and other social networking, eBay and Wikipedia.

In developing countries there are well known examples, like the Grameen Bank in Bangladesh where microcredit has been provided to 100,000 'phone ladies' who then rent out airtime. There are also new ideas like Drishtee, below.

The electronic village shop – a possible future

Drishtee – the Hindi for vision – is the name of a business that was set up in 2000 by a group of young people to bid for a government contract to deliver government services electronically to villages – handling land registration, dealing with taxes and so on. It is a sort of equivalent of the village shop or post office in a world where few people have personal computers.

Drishtee identifies a local entrepreneur and provides him or her with a 'kiosk' – a simple stall with a computer – which allows villagers to transact business with the government. There are now 1,000 kiosks, the business is making a profit and Drishtee has plans for 10,000 kiosks in 2008.

They have gradually been taking on new roles and providing new services – selling village handicrafts to the cities, offering distance learning lessons in English – and are now experimenting with offering health consultations through a form of telemedicine.

In a development backed by Microsoft, the first few kiosks are offering a consultation for just over $1. The patient has their temperature, blood pressure, ECG and pulse checked mechanically in the kiosk – with the owner assisting with language and technique as necessary – and is then put directly through to a clinician. Drishtee claim that the cost is much less than it would be for individuals to travel elsewhere.

This programme is only just starting – mistakes will no doubt be made – but lessons will be learned that will be valuable elsewhere.

Microcredit has proved to be an extremely flexible way of improving the lives of the poor. It has improved health and helped people to manage crucial life events. The box below sets out just one example provide for *Global Health Partnerships*

by Professor Sheila Leatherman of the School of Public Health, University of North Carolina.

Credit with Education

The Credit with Education programme delivers both microfinance and dialogue-based health education and has seen several rigorous impact studies. For example, MkNelly and Dunford have shown in their Ghana and Bolivia studies that mothers' health and nutrition practices can be changed by an integrated programme of banking and child survival education facilitated by one and the same credit agent.

When women successfully participate in Credit with Education, the combined increases in income and assets, and knowledge of good child-feeding practices lead to more nutritious food intake by young children. Participating mothers were more likely to breastfeed their children and delay the introduction of other foods into their babies' diets until the recommended age. They were also more likely to properly rehydrate children who had diarrhoea by giving them oral rehydration solutions. These changes in nutrition and health protection practices paid off in a significant increase in height-for-age and weight-for-age for children of participants.

Similarly, after receiving health education through their credit groups, clients of FOCCAS (a Ugandan MFI) had better healthcare practices than non-clients. Study data indicated that 32% of clients had tried at least one HIV/AIDS prevention practice, compared with 18% of non-clients.

These examples show that there is clearly more scope to review, as Professor Leatherman proposes, the case for using *"microfinance as a platform for the integration of health improvement interventions with credit and savings services as an effective and sustainable approach to the alleviation of poverty and poor health for the poor and very poor in developing nations."*

The Grameen and Drishtee examples show most importantly how these new technologies can change the course of development – developing countries won't follow the same paths we have taken – and that local creativity can change circumstances.

Commercial background

The White Paper *Eliminating World Poverty: Making Governance Work for the Poor* recognises that: *"Economic growth is the single most powerful way of pulling people out of poverty."* [11]

Commercial competition, entrepreneurialism and self-interest are powerful drivers of innovation and opportunity. The danger for the poorest countries and

individuals, however, is that they won't have access to the benefits either of growth or of ICT due to poor infrastructure and lack of capital.

The example of mobile phones seems, in part at least, to get round these two problems.

Almost everywhere in Sub-Saharan Africa there are now mobile phones – by November 2006, 177 million Africans owned a mobile phone[12] among a population of some 750 million. Numbers are also growing faster than anywhere else in the world – with an increase from 136 million in 2005 and from 80 million in 2004.[13]

The largest market in Sub-Saharan Africa, in Addis Ababa, is full of people selling minutes for phones in single units. In Malawi, the only major advertising campaigns when we visited were for Celtel and Carlsberg. In Africa as a whole there are many people who have access to a personal mobile phone, while the clinic they work in has no electricity; and villages where a single mobile phone is rented out for use to neighbours by its owner.

India, Bangladesh – with the Grameen Bank example – and other countries can provide very many similar examples, with mobile phones spread widely and good connectivity in many areas.

It is very important to remember the commercial background to these technological changes in thinking about possible futures.

Business drove – and continues to drive – the spread of mobile phones in developing countries. Celtel, no doubt, had its own business plans; but just as importantly local entrepreneurs saw the opportunities mobiles presented. Farmers and fishermen were the early drivers – phoning ahead to find which markets and ports had the best prices so they would know where to take their crops and catches.

There are echoes here of Reuters in its early days, able to profit by being first in the UK with the news of President Lincoln's assassination.

Here, as elsewhere, is remarkable evidence that if the poor have the tools and the opportunity they will grasp them with both hands – the notion of them being simply passive recipients of aid is unfair.[14]

Nor, of course, has multinational business stood still. Craig Mundie, Chief Research and Strategy Officer of Microsoft, has set out a vision for healthcare in *Information Technology: Advancing Global Health*[15] – a future where technology can really benefit the poor, using greater machine-to-machine interaction to reduce costs, cut out processes and reach remote areas.

We met him in Seattle where he showed us a mocked-up version of an icon-driven PC, which could be used by an illiterate woman to describe her child's

illness. The data was transmitted to another machine that arranged it according to protocols into a useable form and then – and only then – passed it to a clinician for attention.

... government needs in some way to subsidise or pump-prime investment for the poorest

This may not be immediately applicable today, but one can sense something of the shape of the future here in Craig's insight that only through greater use of machines can we achieve the scale poor countries need, at a cost they might be able to afford.

Craig also told us how he saw this as a businessman. *"At the moment,"* he said, *"we only have around 1.7 billion customers and don't serve the other 4.9 billion or so."* Of those 4.9 billion, he believed about 3.9 billion had some element of disposable income and could – as we have seen with mobile phones – buy technology if it was cheap enough. For the other billion he thought governments, national and international, would have to bear the cost of bringing them into the digital age.

Similar ideas were expressed to us by Intel, which has already produced a $200 dust-proof computer that can run off a car battery. The company is now looking at how it can reduce costs further and make the machine even more robust in order to create products both for the individual and for government-sponsored markets.

The commercial point, that some products can be made at a price for people with a small disposable income but that government needs in some way to subsidise or pump-prime investment for the poorest, is crucial.

It underpins the importance of the relationship between commercial interests in 'emerging markets' and government action in 'developing countries' in together helping lift the poor out of poverty.

Government intervention for the poorest

The mobile phone spread quickly through developing countries. But, as Department for International Development (DFID) staff have suggested in discussion, this could be the exception. Some other innovations, at least, need investment and intervention by government before they can benefit the poor.

This is the case with vaccines and western medicines. The UK Government has led the way in championing both public/private product development partnerships and 'advanced market commitments' to incentivise development of drugs and vaccines for diseases common in developing countries – which would not otherwise be commercially viable because the developing countries could not pay the full costs for them.[16]

It has also been very active in the various schemes to make medicines available more cheaply to the poorest.[17] For example, the Government's main multilateral

investment in health is via product development public/private partnerships (PDPs), for example. These have been developed since the 1990s as a way of overcoming the lack of research and development investment in technologies for neglected diseases, which disproportionately affect the poor.

Between 1975 and 2000, for example, only 13 new drugs were licensed for tropical diseases (1% of the total new licenses issued). Since the emergence of PDPs, there are over 65 potential drug candidates in development, and three to five new drugs are expected to be registered over the next two years. The UK is the leading government donor to PDPs; the Gates Foundation provides some 70% of aggregate PDP funding – but most PDPs were constituted to need a mix of public and private donations.

Investment and lack of capital more generally are absolutely crucial issues. Here, the importance of good governance – creating confidence and stability – is critical. The UK Government's most recent White Paper, *Eliminating World Poverty: Making Governance Work for the Poor*, takes governance as one of its principal themes for this and other reasons.[11]

The UK Government owns, through DFID, CDC Group plc, which is a 'fund of funds' with a remit to *"maximise the creation and growth of viable businesses in poorer developing countries, through responsible investments and mobilising private finance"*. It first invested in mobile phone technology in the early 1990s. It subsequently became the second largest investor in Celtel, gave Celtel management advice, encouraged it to apply good employment practices and paved the way for other organisations to invest in the company.

Businesses in the developing countries have particular incentives to innovate and work with their governments and civil society. The World Economic Forum is seeking to employ this commitment and energy in creating partnerships of international and local business to support development with skill transfer and best practice development in health. Its White Paper *From Funding to Action: Strengthening Healthcare Systems in Sub-Saharan Africa* identifies five strategic challenges where private sector organisations could play an important role alongside government and aid agencies.[18]

These are impressive examples. There appears to be additional scope, however, for taking this partnership between business and government further in health by tapping into UK experience and expertise. There are companies in the UK that manufacture specifically for the developing world and rely to a large extent on selling their products to governments and aid agencies.

A good example is Star Syringe Ltd, which, since 1996, has manufactured and licensed Auto-disable (AD) syringes. These are particularly important in developing countries where syringes may be re-used many times, thus spreading disease. With a recent innovation, these syringes are now self-aspirating and even easier and safer to use.

Star has now won several awards. It was recognised with the Queen's Award for Industry in 2006. However, Marc Koska, Star's founder, has had a great deal of difficulty in establishing the product.

Such innovation is not limited to commercial organisations. Many charities, such as Practical Action, also provide low-tech solutions for needs and problems in developing countries.

Here as elsewhere, individuals have driven innovation through their own imagination and passion. Here as elsewhere, there is scope for government to create the environment and the framework within which individuals and organisations can innovate.

A model for this might be PATH, based in Seattle and largely funded by the Gates Foundation, which develops and buys in technologies for developing countries as well as developing vaccines for diseases common in developing countries. They are currently working on female condoms, cooled boxes for transporting vaccines, which can maintain their temperature over many hours, as well as on the development of vaccines.

PATH has identified the UK as a country with many innovators and has put forward a proposal to help develop an equivalent organisation in the UK so as to bring still more talent into the effort to find new, cheap, applicable solutions.

Conclusions

This chapter has provided a brief overview of technological and commercial innovation. Two main conclusions stand out.

First, in looking at how we can help developing countries get the health benefit from ICT, there is a pressing need to bring the innovators in digital technology and its application in health together with the experts in international development. Together, their shared creativity could start to realise the potential for cheaper, faster, more effective ways of improving health and health care.

There are many UK bodies already engaged in the first area, whose efforts could be enhanced by greater drive and recognition from government and by greater coherence and – the topic of the next chapter – much greater shared learning and evaluation and better understanding of what works.

While there are international bodies, like the Commonwealth Business Council, which are explicitly focusing on sharing learning and building common understanding and standards, there is much more to be done.

Secondly, there is much more scope to look at how ICT can support local entrepreneurs and local creativity. This will mean helping to provide a structure

and environment – with training and incentives – that enables local entrepreneurs to find new solutions and new ways forward.

The UK Government and other international organisations already work alongside commercial interests to make sure the power of commercial competition and innovation can focus on the needs of the poorest and be made available to them.

In the recent White Paper *Eliminating World Poverty*,[11] the Government commits itself to improving access to finance, for example by supporting micro-finance initiatives and entrepreneurialism through the Africa Enterprise Challenge Fund. It could develop new means of providing very practical support to the small commercial interests alongside the work it does with the larger concerns.

Recommendation 14

Against this background, I recommend that 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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12

Evidence, Knowledge and Research

Summary

This chapter:

- Describes recent developments in the management of health research in the UK – and argues that as a new research strategy for development is prepared, there needs to be a focus on the practical application and use of evidence and on proven good practice in delivery
- Identifies the lack of methods and means internationally to spread good practice in a systematic fashion – and notes the early international efforts to address this
- Describes the UK's experience in all aspects of evidence use and knowledge management – and argues that it has a great deal to contribute in supporting international plans to organise healthcare knowledge and find ways of spreading good practice and in supporting countries with their own knowledge services.

It is the forging together of biology, bytes and broadband that will make a revolution that will ... be at the heart of healthcare

Bill Castell

More than 20 years ago the Medical Research Council (MRC) unit in the Gambia developed the insecticide-treated bed net.

Today the Wellcome Trust is supporting 'Diagnostics for the real world', the development of robust rapid diagnostic tests suitable for the environment of developing countries.

Both are very practical examples of the many ways in which UK research is contributing to improving health in developing countries.

The world of biomedical research is changing very rapidly. The digital revolution, described in the last chapter, is accompanied by a revolution in biology – together they are set to transform our knowledge and the way we can use it in the future.

Sir Bill Castell, in a visionary speech to the Pacific Health Summit in June 2005, set out the scene and painted a picture of the future:

"This is transformational technology at its most powerful, equal in impact to the combination of iron, water and coal that created the first industrial revolution. DNA means little without massive analytical processing, and raw SNP analyses only become capable of transforming clinical practice through the connectivity of epidemiological data with individuals. It is the forging together of biology, bytes and broadband that will make a revolution that will not just be at the heart of healthcare, but of the interlinked development of our overall economy." [1]

The impact of this revolution will be felt in many ways – in new medicines, more specifically targeted at individuals and genetic groups, and new vaccines. It will also be seen in new devices that can transmit clinical information over a distance and help anticipate and prevent ill health through improved diagnosis and analysis.

This revolution plays to UK strengths. It both enhances the role the UK can play in supporting international development and, as Sir Bill implies, helps strengthen the UK economy.

There is a very impressive tradition of UK research collaboration internationally, which has been led by Wellcome and the MRC as major funders and delivered by very many universities and institutions (see box on facing page).

We have been privileged to meet some of their researchers and collaborators in Africa and India and seen something of their work in crucial areas such as HIV/AIDS.

It is apparent, here as elsewhere, that these collaborations are moving from an exclusively UK focus to one where Indian or African institutions are increasingly taking on – or wanting to take on – a more powerful role. The continuation and further development of international partnerships will clearly be of vital

importance for developing countries as well as for the UK's own standing in health-related research.

The Medical Research Council

The MRC was set up in 1913. It contributes to health in developing countries through:

- Capacity building for clinical research
- Health systems research
- New medical knowledge
- Developing research ethics and governance.

It spends around £30 million per annum as part of its global health portfolio.

Infrastructure

MRC expenditure on clinical trials in Africa (usually in partnership with other funders) is often accompanied by investment in infrastructure, such as:

- HIV clinic (building and staff) in Entebbe for DART (Development of Antiretroviral Therapy in Africa) trial
- Paediatric clinics (building and staff) in Entebbe and Kampala for ARROW trial (DART for children)
- Mother to baby clinic (building and staff) in Entebbe for helminth studies
- Paediatric clinic in Fajara, the Gambia (building and staff)
- Research clinic (staff and equipment) at Farafenni Hospital, the Gambia
- Cryptococcal infection clinic for patients with AIDS in Masaka, Uganda.

These investments in infrastructure are linked to recruitment of new staff (Entebbe did not have a single paediatrician before establishing the ARROW trial facility), acquisition of data management skills, access to information (open access journals, etc), improved patient care (for trial participants) and career development.

The MRC also undertakes health systems research, as the following example shows.

The DART and ARROW trial, and related studies in Uganda (Centers for Disease Control and Prevention (CDC)-funded trial at Jinja), are looking at how best to optimise delivery of antiretrovirals to patients, particularly in resource poor rural communities where there is no access to the high-tech laboratory services that are normally associated with CD4 counts, viral load and resistance monitoring for HIV in the West.

The Wellcome Trust

The Wellcome Trust is an independent research-funding charity-based in the UK, established in 1936 *"to foster and promote research with the aim of improving human and animal health"*. It supports over 3,000 researchers in more than 50 countries. Its total spend is about £450 million per annum with £50 million for international activities.

Its Global Health Strategy is to:

- Broaden the research base for scientific endeavour in under-resourced environments
- Support areas of science that have potential for increasing health benefits for people and livestock
- Support international networks and partnerships focused on problems of resource-poor countries.

The Wellcome Trust, like the MRC, makes a direct contribution to service delivery and development alongside its research, as this example shows.

A partnership between the Ministry of Health of Tanzania, the International Development Research Centre (IDRC) and the Canadian International Development Agency (CIDA), the Tanzania Essential Health Intervention Project (TEHIP) involved local researchers, local and international advisers, district health managers, health facility staff and entire communities.

The project designed, developed and tested a series of tools and strategies to help the district health management teams target their limited funds into high priority health interventions that could directly respond to the greatest health needs of the communities they served. TEHIP also increased health managers' capacity to appreciate and use information and evidence derived from research for planning and routine decision making.

As a result, child mortality in TEHIP districts progressively dropped by around 40%.

Biomedical research is one of the UK's strengths and in 2006 the Chancellor of the Exchequer and the Secretaries of State for Health and for Trade and Industry asked Sir David Cooksey to review health research funding.

His review,[2] published in late 2006, recommended a more strategic approach to the planning, funding and delivery of health research. The Government accepted the findings of his review and agreed to establish an Office for Strategic Coordination of Health Research to enhance coordination and ensure more coherent funding arrangements.

At the same time, the Government accepted Sir David King's proposal to establish a high-level forum for collaboration on development research in the UK.

These two new initiatives, together with the Government's very welcome plans to increase research funding for development, provide a very strong foundation for the future.

Sir David Cooksey in his Report drew attention to the need for a continuum from basic research activity through translation to the development of therapies, followed by help with delivery of the innovative medicines and therapies where they are needed. The new arrangements will ensure greater coherence in the first parts of this continuum, but it is not yet clear how they will address the last.

There is a need for a rigorous approach to the use of research and evidence in practice. It will be very important to ensure that 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 reality in order to avoid the sort of problems described below.

Applying the evidence – learning and sharing

In Ghana we saw an innovative scheme to help local entrepreneurs market insecticide-treated bed nets to mothers.

In Tanzania a Wellcome-supported project reduced child mortality in the district covered by around 40%.

In India we saw the excellent work done by the Open University with Vellore Medical College to improve the knowledge and skills of clinicians caring for patients with HIV/AIDS.

In many parts of the world we came across similar projects with excellent results; but one of the most striking things was the lack of learning from each other.

Approaches that were successful in one location were not being applied elsewhere. Equally, there are no doubt examples of what has failed in one location being applied elsewhere. While evaluations were often being done, there appeared to be no means for the systematic and rigorous spread of good practice.

There also appears to be no systematic means of applying evidence, making sure we use what we already know. As Pang, Gray and Evans write in an article in the *Lancet:*

"Knowledge is the enemy of disease. ... Applying what we know already will have a bigger impact on health and disease than any drug or technology likely to be introduced in the next decade."[3]

Applying what we know already will have a bigger impact on health and disease than any drug or technology likely to be introduced in the next decade.

Pang, Gray and Evans

There are two issues here. We need to find better ways to:

- Create the evidence in the first place – the task of research and evaluation
- Make the evidence available in ways that people can use – making knowledge accessible to health workers, policy makers and the public alike – and, as part of this, finding means of sharing and learning from each other, across national, institutional and language boundaries.

A great deal of attention has traditionally been focused on the first of these issues. The second is as important. Having knowledge by itself does not mean that it will be applied. There are many barriers to its application in practice in any society.

These issues are now becoming the focus of a great deal of attention from policy makers internationally. The World Health Organization, the European Union and other international organisations are adopting policies on knowledge management. The WHO itself has a department focused on it. Its African Regional Director, Dr Luis Sambo, set out plans for developing knowledge management at its meeting in September 2006.[4]

There is also now a gathering momentum around the need to create centres of best practice knowledge and spread, with the New Partnership for Africa's Development (NEPAD), for example, planning to develop such a centre in Africa modelled largely on the European Observatory.[5] The World Economic Forum in its White Paper is proposing the establishment of best practice management and leadership centres to exploit the potential of the African private sector to contribute to public services.[6]

India has set up a Knowledge Commission to look at the whole field of knowledge management, including health, and to report directly to the prime minister with proposals.

The following examples illustrate two different ways in which knowledge management is developing – the one specifically organic and cooperative, the other more planned and directed.

Knowledgment management systems

ePortuguese

ePortuguese is a series of initiatives to promote better health in the Portuguese-speaking countries. It consists of:

- Virtual Health Library
- Blue Trunk Library
- Health information through videos
- Health InterNetwork Access to Research Initiative (HINARI) training workshops
- Exchange of local experience through communities of practices (BLOGS)
- Development of human resources for health
- Electronic medical journals in Portuguese
- Use of web page to disseminate country information
- Discussion forums
- Distance learning
- Health Academy.

Knowledge Management for Public Health (KM4PH)

KMPH4 is a global partnership of public health associations, schools and institutes worldwide. Key partners are the WHO, together with the World Federation of Public Health Associations (WFPHA) and the International Association of National Public Health Institutes (IANPHI) as well as their members.

KM4PH is a global knowledge-sharing network for public health supported by:

- A global database of public health expertise (the KM4PH database)
- An online communications platform (University of Iowa Global Public Health Campus)
- Other knowledge resources including the HINARI, Global Health Library (GHL) and the eGranary Digital Library
- Training in leadership of knowledge management for health.

Part of this activity is designed to support the efforts of developing countries to learn from each other and from their own experience. The new Public Health Foundation for India has the ambition not only to create public health standards appropriate for India but also to learn lessons that may be useful for other developing countries. South Africa is developing memoranda of understanding to share learning and expertise with all other African countries.

The UK experience

These are all very familiar issues for the NHS in the UK. As Chief Executive in England, I too was interested in how you spread learning from one place to another, how evidence could be applied and how knowledge is used by policy makers and clinicians.

We must be very cautious in extrapolating from the UK to countries with very different cultures and resources. Nor should we give the impression that these problems have been solved in the UK – they haven't, and countries can learn from our failures as well as our achievements – but some of the methodologies and approaches can be relevant.

One of the key tasks of every health system is to make current knowledge accessible to practitioners (whether in a developed or developing country), set standards based on evidence and create, where appropriate, guidelines and protocols.

Making relevant knowledge available to clinicians is perhaps even more crucial in developing countries where costs are even more constrained – and therefore any treatment decision carries enormous opportunity costs – and where practitioners are frequently isolated from colleagues and may be semi-skilled and trained only in certain aspects of treatment and care.

Providing support to the isolated practitioner – or the district medical officer described in Chapter 3 – with updated knowledge, advice and diagnostic and therapeutic support is surely one of the tests of success in rural Africa or India.

In the UK we have been on a journey towards creating an evidence-based health system which has had many steps. Those described below refer explicitly to England, but in almost every case there were similar – and in some cases the same – arrangements in the other three UK countries.

Making the findings of research accessible

- In 1992 the **Cochrane Centre** was established to deal with the problem of making the knowledge from research available to practitioners. In health – as in development – many thousands of studies have been done, each with slightly different methodologies, different variables and different starting points

– even when they are ostensibly concerned with the same question. The Cochrane Centre helps practitioners to understand the available evidence by carrying out meta-analyses of these studies to draw out the learning and describe the evidence it is based on.

- This was followed up in 1998 with the establishment of the **National Electronic Library for Health** which provides guided access for practitioners to the whole range of textbooks and journals.
- During the same period the Department of Health developed a National Cancer Plan and **National Service Frameworks** for major disease areas – such as coronary heart disease, diabetes and mental health – which brought together, through consensus meetings and expert opinion, current knowledge and set out a clinical and organisational framework for tackling these disease areas. This led, for example, to the establishment of cancer centres and the creation of both clinical guidelines and management targets for treatment.
- There is no global benchmark for clinical processes providing maps of evidence-based and best-practice patient journeys. Most healthcare services have attempted, with varying degrees of success, the rapid development of clinical pathways, protocols and guidance over recent years, often in partial and fragmented ways and based on different methodologies. The **Map of Medicine** is regarded within the NHS (England and Wales), and perhaps worldwide, as the most comprehensive and easily accessible offering:
  - patient pathways in over 500 conditions and continually expanding
  - all developed collaboratively by independent clinicians and subject to critical review and scrutiny by all clinicians
  - easy access directly to the evidence on which the pathway is based
  - able to be modified to suit particular local conditions or practices – a unique feature
  - developed in and with the NHS on public service principles, with the content and software available licence-free to developing world countries.
- Evidence is also used by and produced by the many NHS organisations – such as the **National Institute for Health and Clinical Excellence**, the **Healthcare Commission** and the **Health Protection Agency** – which in turn provide advice and guidance to practitioners, policy makers and organisations.

Spreading good practice and supporting practitioners

- In 2001 the **NHS Modernisation Agency** was created explicitly to identify and spread good practice. It focused on areas where the NHS had targets – such as reducing waiting times and improving survival from cancer and coronary heart disease. It worked both through providing explicit examples of what worked in practice and through using tested techniques to help organisations learn and adopt new practices.

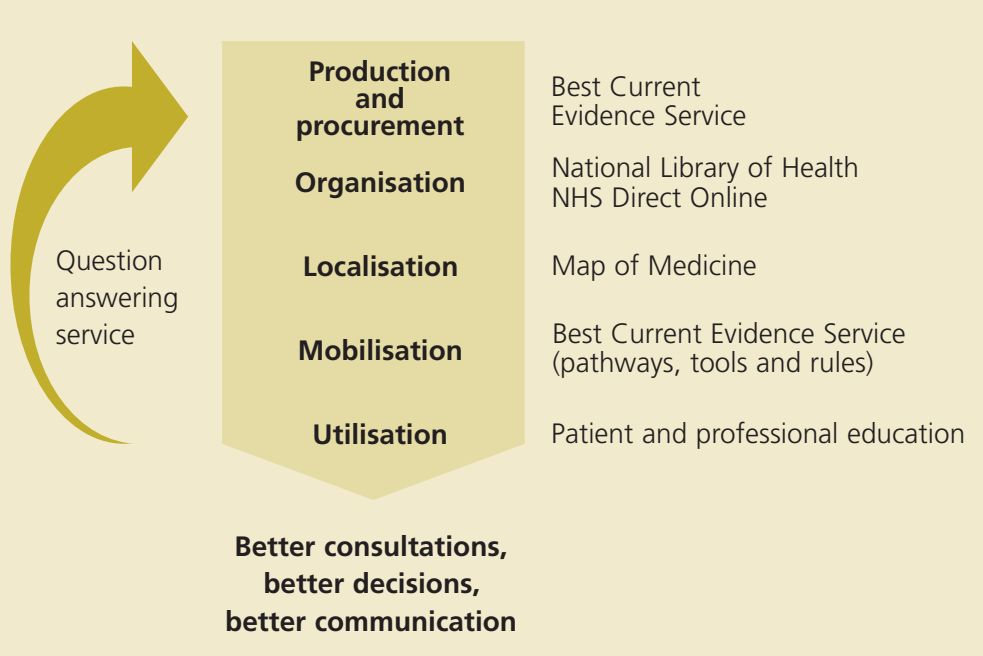
- The Modernisation Agency has been replaced by the **NHS Institute for Innovation and Improvement** which brings its functions together with an innovation centre, with the aim of spreading good practice and introducing innovation more rapidly into the NHS.
- There are now a number of web-based communities of practitioners, including the international one Child 2015, which promote mutual learning, consultation between members over issues and patients, and education. The most extraordinary success story is probably **Doctors.net.uk**:
  - With more than 135,000 members, exclusively doctors and run by doctors for doctors, it is the largest web-based community in the UK and probably the world.
  - It offers secure clinical discussion for advice and co-consulting. A doctor can post a question about the treatment they are offering a patient and receive advice from other doctors very quickly.
  - It has the ability to target information at particular groups of doctors and is now extensively used for updating, educating and issuing hazard alerts.
  - In a new development, its members are building a 'Medipaedia'.
  - The potential for further development is enormous.

Providing information and advice for health professionals and planners and for the public

- **Eight Public Health Observatories**, set up by the Department of Health, act as surveillance centres, collecting, monitoring and analysing public health data. They provide knowledge and information to inform decision making at local, regional and national levels.
- **NHS Direct, NHS Direct Online** and **NHS Direct Interactive TV** (in England) and **NHS 24** (in Scotland) provide ways in which – through phone lines, TV and computers – members of the public can access knowledge and discuss issues with clinicians. They rely on a combination of decision algorithms – based on evidence and similar to the guidelines and protocols described above – and trained staff to provide advice. In 2006 close to 6.5 million calls to NHS Direct were answered and over 19 million people used the NHS Direct Online website.[7]
- The **NHS**, through a very wide variety of media, provides information about health and services to patients and the public and, as it moves the focus more towards health promotion, is set to increase this enormously in future years.

These developments were brought together in England into a **National Knowledge Service** in 2006 under the leadership of Sir Muir Gray who has been associated with many of these initiatives. He has outlined the Service in Figure 7.

Figure 7: National Knowledge Service



Source: see Reference 8

The relevance of the UK system

While the UK experience must be treated with caution, most of these organisations have already been approached by developing countries to work with them.

The UK experience has also shown how the application and use of knowledge is not a simple process of identifying what works and telling the practitioners – or indeed the public – to follow the instructions.

Our experience in England has been that, while it is important for policy and decision makers to set evidence-based standards, clinicians largely change their practice only as they practise – 'pulling' knowledge as they need it, rather than accepting it as it is 'pushed' towards them.

It is difficult to overstate the importance of finding the right way to work with clinicians. In the UK we are greatly indebted to the Institute for Healthcare Improvement (IHI), based in Boston, USA, for the learning about how to systematically introduce service improvement.

Examples from Kenya (see box below) help make the point that knowledge is not useful unless it is applied in practice in the circumstances faced by individual clinicians.

The practice of paediatric care in Kenyan district hospitals

The results of a survey carried out by the Kenya Medical Research Institute of 14 first-referral hospitals in Kenya revealed considerable deficiencies in case management and prescription of medicines. For example:

- Malaria

Some 60% of inpatients were diagnosed and treated for malaria, but only 15% had laboratory confirmation and in the case of 19% it was despite a negative test. Only 3% of those treated with quinine were given the recommended loading dose. Dosages were frequently in excess of nationally recommended levels.

- Pneumonia

Signs for disease severity and choosing treatment were rarely documented. Oxygen demand often outstripped supply. Three hospitals had serious problems with flow meters.

- Diarrhoea/malnutrition

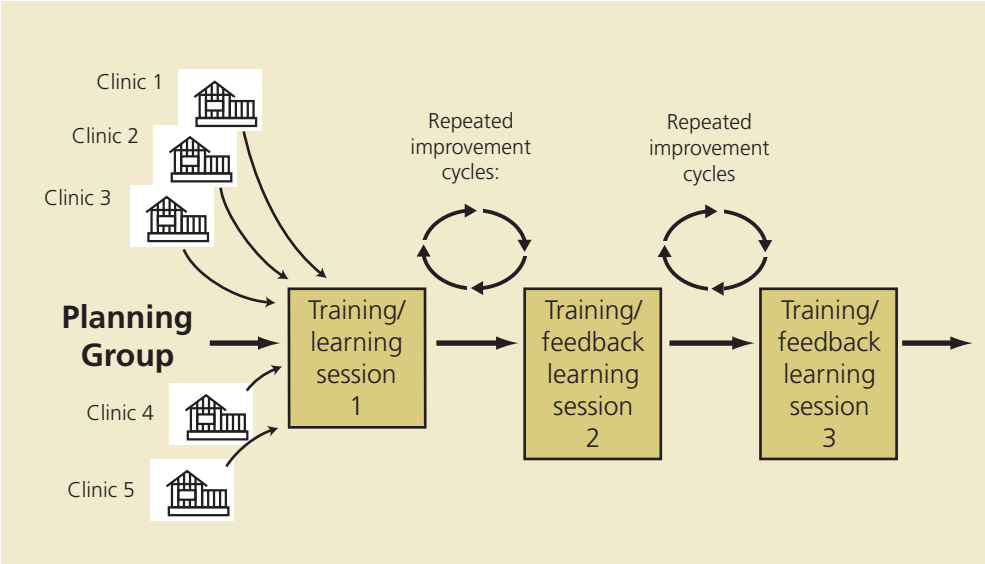
Of 27 children clinically diagnosed with severe malnutrition, only 4 were prescribed milk feeds of appropriate volume for their weight. No hospitals had Resomal, the WHO-recommended rehydration solution.[9]

These examples show knowledge that is widely available simply not being applied in practice. There may be many reasons for this – clinicians may be too short of time; there will undoubtedly have been shortages of resources; there, perhaps, were no systems for checking that treatment was applied properly. In many such cases, there may be relatively simple improvements in systems that would improve the outcomes.

IHI has, over more than 20 years, developed ways for systematically improving health systems that are relevant in developed and developing countries alike. They work collaboratively with local providers, building capacity to change and disseminating knowledge and best practice about improvement.

This collaborative improvement model is illustrated in Figure 8.

Figure 8: Tools for system change: collaborative improvement model



Source: see Reference 10

IHI is currently working in South Africa and Malawi and, supported by The Health Foundation, and working with others including Women and Children First, is helping local partners develop their own systematic approach to HIV/AIDS and to reducing maternal deaths. Interestingly, they are combining this approach with public education and community empowerment – tackling learning and support for health professionals and the public at the same time.

In doing so they are responding to the fact that the use of knowledge is not just a simple story of how professionals use apparently objective scientific knowledge, but it is also about judgement and about public and patient behaviour and attitudes.

Another important part is to create the conditions for learning and knowledge management. For example, in Kenya the Aga Khan Foundation is establishing programmes of knowledge management, which are precisely about helping people to understand and use knowledge in a practical way.[11]

In a story in some ways reminiscent of the MMR debate in the UK, we were told in India of the problems of getting Muslim parents to accept immunisation for their children because the parents thought this was really sterilisation by another route. It was evident that the parents had little trust in the authorities and – because history and myth alike suggest that stranger things have happened – they could not be coaxed into compliance.

It seems that these public health goals can only be achieved through greater control and decision making by the population and through their own programmes of health education and health promotion alongside those for the health professionals.

Conclusions – partnership and shared learning

It will be evident from the account in this chapter that the developments in knowledge management are mostly very new and that the UK has a great deal to learn about how to make knowledge accessible to its own health workers.

There is therefore scope for an enormous amount of joint learning and partnership between developed countries, between developing countries and between developed and developing countries. There is room for experimentation, pilot projects and demonstration sites, and a need for fast learning, good feedback and evaluation, and dissemination of results.

Part of this will undoubtedly require the development of best practice centres and networks within and between developing countries – which are able to draw on expertise in local universities and healthcare institutions as well as on experience anywhere in the world.

Such experimentation and piloting could involve a number of UK institutions and build on existing learning. They would need to cover the whole range of areas described earlier:

- The creation of guidelines and protocols – possibly learning from the Map of Medicine
- Spreading best practice systematically – learning from IHI and the NHS Institute for Innovation and Improvement
- Access to research and evaluation – possibly learning from the National Electronic Library for Health or the Medipaedia
- The ability to co-consult – learning from Doctors.net.uk
- Health information and monitoring – possibly learning from the observatories in the UK and Europe
- Continuing education and updating – through many UK institutions, including potentially the BBC World Service Trust.

But it should also be clear that there are real opportunities for developing countries to use the experience of the UK and others very effectively. Part of the problem for developed countries in introducing more 'evidence-based' medicine has been the baggage of history – the attitudes, practices and institutions which wittingly or not have resisted some of the changes.

Developing countries have the opportunity to do things differently. As the Ethiopian minister of health said to us, *"We have the opportunity to leapfrog your developments"*.

UK experience and expertise means that we have the opportunity to help them and learn for ourselves at the same time.

Recommendation 15
I recommend that 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.

Recommendation 16
I recommend that 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 – which can make relevant knowledge accessible to their health workers and public.***

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- A number of other people, including Penny Jones and Geoff Lee, have put in a great deal of voluntary effort in particular areas and for specific periods.

- The Right Honourable Rosie Winterton MP, Minister of Health, who has been a champion of links between health and international development for many years, and chairs the inter-Ministerial group on Health Capacity in Developing Countries. I have also very much appreciated the support of many others in the Department of Health, including Sir Liam Donaldson, Hugh Taylor and David Nicholson, and other colleagues, including Nick Boyd, Dr Paul Johnstone, Dr Andrew Furber, Anna Maslin, Nick Banatvala, Debbie Mellor and Liz Kidd.

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- Professor Eldryd Parry, who has been a personal inspiration to me and many others, and his colleagues at THET who have pioneered Global Health Partnerships over many years.

Visits and meetings with people from developing countries

I have visited a number of countries and met people from developing countries at international gatherings in Geneva and Addis Ababa. I would like to thank the ministers and their staff who have explained their issues and needs so courteously and the many people from the UK's High Commissions and DFID who have looked after me so well on these occasions:

- The Ministers and their officials who hosted me in their countries including the Minister of Health, South Africa, Dr Mantombazana Edmie Tshabalala-Msimang; Minister of Health, Malawi, Hon Marjorie Ngaunje; Minister of Health, Ethiopia, Dr Tedros Adhnom Ghebreyesus; Minister of Health, Ghana, Major RTD Courage EK Quashigah; Minister of Finance and Economic Planning, Ghana, Nana Juaben-Boaten Siriboe; Minister of Health, India, Dr. Anbumani Ramadoss; Minister of Health, West Bengal, Surya Kanta Mishra.

- The Ministers and officials from other countries who met with me including the Minister of Health, Uganda,The Right Hon Stephen Mallinga; Minister of Health, Botswana, Hon Professor Sheila Tlou; Minister of Health, Cameroon, Olanguena Awonourbain; Minister of Health, Mozambique, Dr Paololvo Garrido; Minister of Health, Kenya, Hon Charity Kaluki Ngilu; (Deputy) Minister of Health, Zambia, Chilufya Kazenene and the Permanent Secretary Dr Miti; Minister of Health, Pakistan, Mr. Muhammad Nasir Khan; and the Minister of Health Jamaica, Horace W Dalley.

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Meetings in the UK

I am also grateful to the large number of people I have met with in small or large groups in the UK. Unfortunately, I cannot list everyone and will only list here the larger meetings. These include:

- The people who attended Reference Group meetings in April and July 2006, and contributed their thoughts and advice throughout the year including: Victor Adebowale, Lola Banjoko, Jim Dornan, Phillip Freeman, Mark Goldring, Helen Grant, Paul Johnstone, Penny Jones, Max Lawson, Geoff Lee, Laurie Lee, Carolyn Miller, Barbara Parfitt, Michael Parker, Eldryd Parry, Fiona Samuels, Barbara Stocking, Douglas Wilkinson, Keith Willett, Michael Worton and Asad Zoma.

- A meeting organised for me by the UK One World Linking Association (UKOWLA) and BUILD in Marlborough, in July 2006, which brought together a very wide range of organisations, large and small, involved in all areas of international development.

- An international meeting with representatives from Cameroon, Uganda, France and Canada on *Strengthening human resources for health through North-South partnerships: Revitalising education and training*, held at the Royal College Of Obstetrics and Gynaecology, in July 2006.

- A UK meeting on *Education and training on health in developing countries: the UK contribution*, in October 2006.

- A meeting on Knowledge Management, in November 2006.

- A *Workshop to review recommendations on how DH/NHS can respond to international health emergencies*, in November 2006.

- A meeting of NHS representatives and professional bodies, organised by the NHS Confederation, in November 2006.

- A meeting of UK government colleagues from England, Scotland, Wales and Northern Ireland on collaboration on international health work, in November 2006.

- A meeting with Universities UK health and social care policy committee, in November 2006.

Papers

I have received a large number of papers from a variety of organisations and individuals, including:

- *Royal Colleges/Faculties:* including the Royal Colleges' International Forum, Faculty of Public Health, Royal College of General Practitioners, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health, Royal College of Pathologists, Royal College of Physicians, Royal College of Psychiatrists and the Royal College of Surgeons.

- *Academic Institutions:* including Universities UK, the Association of Commonwealth Universities, the Institute of Child Health, the Institute of Psychiatry, King's College Dental Institute, King's College London, the Liverpool School of Tropical Medicine, the London School of Hygiene and Tropical Medicine, the Open University, University College London (UCL), the University of Birmingham, the University of Keele, the University of Leeds, the University of Manchester, the University of Southampton.

- *Charities and consultancies:* including the Tropical Health Education Trust (THET), VSO, Merlin, the Primary Trauma Care Foundation, Child 2015, World Orthopaedic Concern, HLSP and Liverpool Associates in Tropical Health (LATH).

- *Arms length bodies and other agencies:* including the NHS Confederation, Healthcare Commission, Health Protection Agency and National Institute of Clinical Excellence.

Finally

My thanks and appreciation to the very many people and organisations across the UK and beyond, who have also briefed and advised me over the last year, and given me information. Most are mentioned above or in the report, but there are also many more.

Nigel Crisp

Terms of Reference

UK Health Service Support for Health and Health Services in Developing Countries

The Review

The Prime Minister, with the Secretary of State for International Development and the Secretary of State for Health, have asked Lord Crisp to review how the UK's experience and expertise in delivering health services, can be used to support the developing world.

The Department for International Development already provides an enormous amount of support to improve health in the developing world, and many NHS organisations have links with institutions there. Lord Crisp will look at what more can be done to help developing countries, access UK capacity and expertise to improve the health of their people.

Lord Crisp will report his findings and recommendations to the Prime Minister and the Secretaries of State by the end of the year.

Principles

The review will be based on the following principles:

- **Based on countries' needs:** the review's findings and recommendations will be explicitly based on the needs and requirements of the developing countries as identified and expressed by the representatives of those countries themselves

- **Added practical value:** the review will aim to add practical value to work underway by the Government and UK and international agencies and organisations. It will primarily address barriers to progress, gaps in UK efforts and opportunities for further development.
- **Mutuality:** wherever possible the review will look for mutuality of benefit, greater mutual understanding of peoples and communities, shared training, exchange of ideas and staff and two-way development opportunities for staff and organisations.
- **Scale and localness:** whilst the review will look for the benefits of greater coordination, scale and system-wide approaches, it will be sensitive to the benefits of localness, spontaneity, individual activity and creativity.
- **NHS and partners:** the review will seek the involvement of the NHS and its partners in service provision, health promotion, advocacy, industry, education and research.

Operation

In line with these principles, the review will look for practical action to address barriers to progress, gaps and opportunities through taking three different, but overlapping perspectives:

1. Review of the needs and requirements of developing countries for support in the four areas of health, health services, systems capacity building and emergency response.
2. Consideration of how to strengthen existing opportunities for NHS staff, organisations and partners to contribute internationally.
3. Propose action on barriers, gaps and opportunities identified during the course of the review, and identify how these can be dealt with, within existing resources.

The first area will **review the needs and requirements** for:

- Public health capacity building programmes.
- Service capacity building programmes.
- Health system capacity building:
  1) Human resource capacity building – Education and training support (basic training, undergraduate and postgraduate curricular support), CPD support, ethical recruitment to the UK, support to local retention strategies and the release of learning materials to support curricular.
  2) Management capacity building.

3) Physical resource capacity building – Education and training support for buildings and medical equipment utilisation and maintenance.

4) Clinical governance and patient safety capacity building.

5) Research and development, including identifying any current and future technological opportunities for health improvement.

- Emergency response and disaster relief.

The second area, **strengthening existing opportunities**, will cover:

- Widening opportunities to contribute via existing NGOs, for example VSO, Merlin, and others as appropriate
- Widening and deepening the existing NHS Links programme.
- Identify opportunities with partner organisations, particularly universities and the Royal Colleges that could be delivered jointly with the NHS.

In the third area, **action on barriers, gaps and opportunities**, early analysis has suggested there is scope for looking at:

- NHS staff terms and conditions, and how these may help or hinder contribution.
- The position of overseas professionals in the UK who may be looking for training, employment and a return to their country of origin.
- The scope for NHS overseas elective programmes – possibly on an exchange basis – for NHS staff in clinical and management training
- A coordinated NHS response to emergency and disaster relief.
- An NHS corporate social responsibility programme.

Organisation and governance

Lord Crisp will report to the Prime Minister and the two Secretaries of State by the end of 2006.

During the year, he will liaise with, and provide interim reports to Ministers and the Permanent Secretaries in the Department for International Development and the Department of Health.

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