

GLOBAL HEALTH PARTNERSHIPS – THE UK CONTRIBUTION TO HEALTH IN DEVELOPING COUNTRIES

In more than five years as Chief Executive of the NHS in England I came across many people and NHS organisations who were working, often voluntarily – in many different ways – 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 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.

As a result of meeting and discussing these issues with many people, particularly in Africa, I have become convinced that partnerships between UK organisations and institutions and those in developing countries – in healthcare and the related fields of education – can play a significant role in development.

These partnerships are only a part of the picture; but alongside aid, economic, political and social development, they are able to assist with education and training, with the transfer of skills and – something that is often highly valued – provide support from colleagues for people who are struggling in isolation to tackle enormous difficulties.

These partnerships are frequently also of mutual benefit. UK health workers often benefit enormously from the chance to work in developing countries – learning new skills and new attitudes as they do so.

What people told me

I started working on *Global Health Partnerships* by looking at the needs of developing countries and 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. All, too, 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.

The contrasts with the UK are stark

Child deaths under 5: in Sub-Saharan Africa 179 in 1000; in UK 6 in 1000

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 \$2231

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 health care to a needy population with the average expenditure 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.

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.

Ultimately, leadership is local and “*Africans will sort out Africa’s problems*”.

UK experience and expertise in health

The UK has in recent years become an undoubted international leader in development and the Department of International Development is recognised as the leading national agency of its kind. The UK's expertise in health – and related education and research - is also very well recognised.

Against this background I reviewed the experience and expertise of the NHS and its partners – in health, education and research – to look for practical ways to help support health and health services in developing countries. This review covered a wide range of areas, where there was clearly scope for further action. These are briefly described in the following paragraphs.

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.

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 are a myriad of organisations and thousands of people involved.

Many organisations are wanting 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.

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.

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.

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 both to make sure that – under the right circumstances - this is properly recognised by training authorities.

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 told me they wanted partnership with UK hospitals, health care schools and other providers and they also wanted some links at national level – with the people designing and managing 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 sort 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.

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

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 background 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. Whilst 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 Health Care Commission (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 NICE and the Health Protection Agency (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.

Tackling the staffing crisis

The World Health Report 2006 estimated 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. Large 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 – whilst 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. Currently it has around 30% of its doctors and 10% of its nurses from overseas. It will remain a global employer of health workers.

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.

This provides an excellent background for the UK to play a significant part in concerted international effort in the future. The UK and other developed countries can now 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

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 spread throughout the world. There are now many mobile phones and computers in use in developing countries – Africa now has more than 80 million mobiles 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 many small scale experiments and initiatives in 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.

Conclusions

This brief survey has highlighted areas where partnerships have the potential to make significant improvements in the lives of people in developing countries. They can particularly make a difference in the areas of

- public health and health systems
- education and training
- making knowledge, evidence and best practice – derived from high quality research – accessible to health workers and the public.

In all these areas there is a great deal of activity. However, there is as yet no wide ranging international studies of the benefits and impact of such partnerships. Much work remains to be done before we understand their scope fully.

Creating true *Global Health Partnerships* does seem however, to have the potential 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**”.*

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