

Global Health Partnerships: The UK contribution to health in developing countries

The Government response

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The Government response

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Forewords

Foreword by the Minister of State for Public Health and Parliamentary Under Secretary of State, Department for International Development

We welcome Lord Crisp's report. This cross-government response to Lord Crisp's recommendations identifies a number of opportunities where the UK can contribute even more effectively to building health capacity in developing countries. We believe that there are significant benefits for developing countries, and indeed the UK health economy, that come from long-term sustainable partnerships in the health sector. What Lord Crisp has to say about developing countries investing in their own peoples' health, about the shortage of trained health workers and weak health systems resonates strongly – and needs underlining. If poor people as individuals are to benefit from the report's analysis it is this Government's responsibility to spell out these messages at every opportunity, in developing as well as industrialised countries. We will ensure his key recommendations are taken forward with the minimum of delay.

The response outlined here is one that will allow these sorts of initiatives to flourish, be of greatest benefit to developing countries and their people, and fit with UK development policy.

Lord Crisp's report and this response are important staging posts in increasing the UK contribution to better global health, international development and poverty reduction. It is a timely reminder of the importance of the health Millennium Development Goals. Our response

shows that we are doing much already, but we can do more. For example, we highlight significant opportunities for healthcare professionals, the NHS and other institutions to participate in international development. We believe that the framework and approach set out in this paper will bring greater clarity and coherence to the way that the 'UK health economy' contributes to positive results. This paper also demonstrates the importance of working across government to pursue international development objectives and supports the case for investing in global health.



The Rt. Hon. Dawn Primarolo MP
Minister of State for Public Health,
England

A handwritten signature in black ink that reads "Dawn Primarolo".



Gillian Merron MP
Parliamentary Under Secretary of State
for the Department for International
Development

A handwritten signature in black ink that reads "Gillian Merron".

on behalf of the Inter-Ministerial Group for Global Health

Foreword by the Permanent Secretaries of the Department of Health and the Department for International Development, the NHS Chief Executive and the UK Government's Chief Medical Adviser

We recognise that UK institutions have valuable expertise and experience in the health sector and that sharing this with developing countries has mutual benefit. We believe that we all have a responsibility to contribute to the Millennium Development Goals. We also know that individuals and organisations in the UK find international work professionally and personally rewarding. Such opportunities may also contribute to NHS recruitment and retention by providing employees with additional challenging and fulfilling opportunities. The NHS can also learn from elements of good practice in developing countries. We welcome the opportunity to respond to Lord Crisp's report and commend this report to the NHS and all UK health and healthcare organisations.



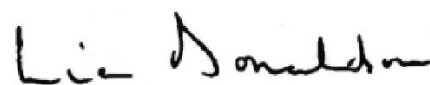
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Summary

Lord Crisp's report highlights a number of areas where the UK and developing countries can mutually benefit from working together. Lord Crisp's key points are that: (i) developing countries must lead and own their solutions; (ii) the UK health economy should add value to DFID's development work, supporting the scale-up of training, education and employment of healthcare workers in developing countries; (iii) more work is needed to identify and share good practice; (iv) the UK should build on the strengths of existing efforts; and (v) the UK Government can encourage a more strategic and coherent response.

Lord Crisp highlights lack of trained health workers (a global shortfall of 4.2 million) and inadequate health systems as crucial barriers to reaching the Millennium Development Goals. Lord Crisp makes the case for the UK to scale up its international availability of institutional and professional expertise and to do so more strategically.

We welcome Lord Crisp's report. We have assessed Lord Crisp's recommendations against a number of criteria, based on those principles identified in the report (Annex 1). This Government response describes some of the exciting work that we are already undertaking, but also outlines opportunities for enhancing the way we work in partnership with developing countries. Lord Crisp describes a response among UK individuals and agencies that is, too often, fragmented. Better coordination is needed and our response describes our proposed approach.

To tackle a global shortfall of healthcare workers and the inadequate health systems in some developing countries requires massive commitment from the international community. In the UK, the Department for International Development (DFID) is the lead government department for international development, working bilaterally with poor countries but also multilaterally with the World Health Organization, the World Bank and partnerships such as the Global Health Workforce Alliance. Our response to Lord Crisp's report is designed to ensure that all those in the UK who are engaging in international development activities complement and enhance DFID's response and do not conflict with UK development policy.

We consider that the NHS and other UK bodies can make an impact on improving the health systems of developing countries. In the first instance, we recognise that

UK staff and institutional engagement in relief and development is a legitimate activity when done well – when it contributes to a strategic response that benefits a developing country partner. When done well, it is also developmental for individuals and UK institutions, and can support broader foreign policy objectives and the UK's development agenda.

To promote a more strategic response, we describe in this paper a framework that provides greater clarity on how NHS agencies and individuals can best maximise their potential to contribute in a sustainable and appropriate way to capacity building in developing countries. Although the Government will set this enabling framework, the mechanisms for implementation will remain largely a local issue and will require local resolution, in keeping with the wider UK health policy. As part of the emerging Global Health Strategy, we have widened the remit of the Inter-Ministerial Group for Strengthening Health Capacity in Developing Countries to one that looks at global health in its entirety. We will also establish a UK International Health Links Centre. We will pilot a scheme to support pension contributions of public sector employees who volunteer to work in developing countries. We are currently undertaking an independent evaluation of existing links to identify best practice. We will use the results of this evaluation to direct new funds we have identified for a future links scheme.

We hope that colleagues outside government will also rise to the challenge of scaling up what works. Those volunteering or working overseas often need to make a number of very personal decisions. Health and healthcare agencies that want to support international health activities will also need to make important strategic decisions.

Finally, we are aware that we still do not have a powerful evidence base to be sure of what works and what does not when it comes to these sorts of partnerships. We are therefore funding work to improve our understanding in this area. This will help us determine where and how we can best scale up our efforts.

We are already doing much that supports Lord Crisp's 16 recommendations. The actions we outline in this report describe our plans to do more to take forward the recommendations in Lord Crisp's Report.

Action plan

The following table summarises actions that we will take forward.

Action	Timescale	Resources	Lead responsibility
Recommendation 1			
As part of the emerging UK government-wide Global Health Strategy, we are broadening the remit of the Inter-Ministerial Group for Strengthening Health Capacity in Developing Countries to be the Inter-Ministerial Group for Global Health (IMG-GH).	Immediate	The Department of Health (DH) will act as the secretariat for the IMG and make resources available for its initial work programme.	IMG, DH and DFID
Recommendation 2			
We will develop and publish a framework for International development. <i>The International Humanitarian and Health Work: Toolkit to Support Good Practice</i> will be part of this framework	As soon as feasible	Funding for evaluating the Toolkit and developing the Framework.* Ongoing costs (keeping the Framework up to date, website administration, technical input).	DH and DFID
We will work with strategic health authority (SHA) Chief Executive Officers (CEOs) who wish to identify lead coordinators in their area.		Costs of any coordination (e.g. at SHA level) would need to be absorbed by the coordinator's employer.	DH and SHA CEOs

Action	Timescale	Resources	Lead responsibility
Recommendation 3			
We will establish a UK International Health Links Centre.	As soon as possible	Funding to staff and resource the Links Centre.*	DFID and DH
Recommendation 5			
We will pilot a scheme to support pension contributions of public sector employees who volunteer to work in developing countries.	April 2008	£13 million over the current Comprehensive Spending Review (CSR) period (2008-2011) to cover pension contributions for volunteers who return to the UK public service within fixed time limits. These funds will be available for health and other professionals.	DFID, Department for Children, Schools and Families (DCSF) and DH
Recommendation 6			
We will ensure that the Links Centre includes a signposting function for individuals wishing to volunteer for humanitarian work.	Once the Links Centre has been established	The costs of the signposting function are included in the Links Centre budget.	Links Centre

Action	Timescale	Resources	Lead responsibility
Recommendation 8			
The Links Centre and DFID health advisers in country will assist countries to make strategic links with UK and other partners.	As soon as the Links Centre is established	Costs included with the revenue costs of the Links Centre.	Links Centre and DFID offices
Recommendation 9			
We are currently taking forward a full evaluation of existing links.		The costs of this are being met by DFID and DH.	DFID and DH
We will allocate funding for a new Health Links Scheme.		We will provide up to £1.25 million annually over the CSR period. Exactly how these funds will be allocated will depend on the results of the evaluation.	DFID and DH
Recommendation 10			
We will work with the Health Protection Agency (HPA) and other arm's length bodies to see how they can increase their strategic international engagement. This work is being taken forward under the Global Health Strategy.	Ongoing		DH and DFID

Action	Timescale	Resources	Lead responsibility
Recommendation 14			
We will map current initiatives in information and communication technologies (ICT) – government, NHS and associated bodies, developing countries, the private sector, multilaterals and non-governmental organisations (NGOs).	By mid 2008	Costs to be identified.*	DFID

*Funding not specified as there may be competitive tender for this work with bidders providing a budget for undertaking this activity.

Costs where given are at today's prices and are not adjusted for inflation.

Introduction

Lord Crisp published his report, *Global Health Partnerships: The UK contribution to health in developing countries*, in February 2007.¹

We welcome the Crisp Report. Lord Crisp's key points are that: (i) developing countries must lead and own their solutions; (ii) the UK health economy should add value to DFID's development work, supporting the scale-up of training, education and employment of healthcare workers in developing countries; (iii) more work is needed to identify and share good practice; (iv) the UK should build on the strengths of existing efforts; and (v) the UK Government can encourage a more strategic and coherent response. We agree with these.

Lord Crisp highlights that lack of trained health workers (a global shortfall of 4.2 million) and inadequate health systems are crucial barriers to reaching the Millennium Development Goals. Lord Crisp makes a strong case for the UK to scale up its international availability of institutional and professional expertise and to do so more strategically.

The 180-page report is full of examples of policy and practice and provides a comprehensive picture of what is going on in this area. It provides important advocacy for what the UK can do to strengthen health capacity in developing countries. It comes with 16 groups of recommendations. Recommendations range from the very specific – the funding of individual non-governmental agencies – to the very broad, for example that the UK assists with international efforts to create ways of identifying and sharing good practice.

This document is the Government response to the Crisp Report. But we also recognise that the report is aimed at others. Many of the recommendations are for our partners to consider – individuals and agencies. We must all take responsibility for moving forward with this agenda. The report also has recommendations for developing country governments.

The Government's development policy is set out in three White Papers and in DFID's recent health strategy.² The Government is now developing a strategy for the way it engages with global health, and a key area will be the way we support health

1 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065374

2 *Eliminating World Poverty: A challenge for the 21st century* (1997); *Eliminating World Poverty: Making globalisation work for the poor* (2000); *Eliminating World Poverty: Making governance work for the poor* (2006); *Working together for better health* (2007).

systems in developing countries.³ UK agencies and healthcare professionals can do more, and many would like to do more. Resource and other pressures mean that we need to focus on what works, and avoid duplicating the efforts of others and adding to the already complex picture for health aid and high transaction costs for developing country partners.

The UK Government has for many years promoted more effective and streamlined global aid for health, with development assistance 'owned' by developing countries. Our response reflects the importance of improving effectiveness and coordination. DFID as the lead department for the UK's international development response already supports UK–developing country partnerships, but we believe that targeting small amounts of additional resource can make our existing resources work harder and bring greater coherence to our efforts.⁴

We have prioritised actions that take forward *Global Health Partnerships: The UK contribution to health in developing countries*. In doing so, we have drawn on a set of eight criteria that were either specified or implied in Lord Crisp's report (Annex 1). We assessed each recommendation against these criteria in deciding whether a recommendation should be taken forward by the Government and, if so, to what scale and over what period. Where we feel the evidence for a particular recommendation is lacking, we say so and outline how we or others should strengthen our understanding in this area.

There are clear benefits for taking forward many of Lord Crisp's recommendations. Foremost is building and sustaining effective health systems in developing countries. Second, the UK can learn from environments where resources are considerably scarcer. Finally, done well, a coherent UK response will enhance our reputation overseas and can support foreign policy objectives.

3 Department of Health (2007) *Health is Global: Proposals for a UK government-wide strategy. A report from the UK's Chief Medical Adviser* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072697

4 Lord Crisp refers to joint UK–developing country initiatives as Global Health Partnerships in his report. We will use this term in the way that Lord Crisp has done, but we recognise that in international development terms the phrase 'Global Health Partnership' has a more specific definition: (i) Buse K (2004) *Global Health Partnerships: Mapping a shifting terrain*. London: DFID Health Resource Centre; and (ii) Operations Evaluation Department, World Bank (2002) *The World Bank's Approach to Global Programs: An Independent Evaluation*.

The process we have used to develop our response

DFID and DH led the process of developing this government-wide response. We received logistic and administrative support from DFID's Health Resource Centre, HLSP.

We have discussed Lord Crisp's report with a large number of interested parties. This was done individually, in small groups and through a two-day workshop in June 2007.

We have also taken into account written evidence from individuals and agencies: governmental and non-governmental agencies, professional associations, academia and organisations from the private sector. These include correspondence written directly to government as well as articles published in medical and health journals.

A full list of organisations and agencies that we heard from is at Annex 2.

Recommendation 1

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

Our response

As part of the emerging UK government-wide Global Health Strategy,⁵ ministers are broadening the remit of the Inter-Ministerial Group on Strengthening Health Capacity in Developing Countries, which was established in 2006, to be an Inter-Ministerial Group on Global Health (IMG-GH). Further details, including terms of reference and membership, will be described when the Global Health Strategy is published. Strengthening health capacity in developing countries will remain a key area for the IMG-GH.

The IMG-GH will not duplicate work done by other ministerial committees such as the Cabinet Sub-Committee on Africa that is chaired by the Secretary of State for International Development. The IMG-GH would also feed into ministerial committees as appropriate and make linkages with other cross-government committees, such as the Africa Capacity Building Initiative (ACBI).

One of the first tasks of a new IMG-GH would be to oversee the development, implementation and monitoring of an NHS Framework for International Development (Recommendation 2).

To feed into the Government's work in the areas described in Lord Crisp's report that we have not highlighted elsewhere in this response, we have identified funding for independent work we may wish to commission.

Priority, importance and timing

This is an important next step, which will be initiated as soon as the Global Health Strategy is published.

Resources

DH will provide the secretariat for the IMG-GH and make resources available for its initial work programme.

⁵ See footnote 3.

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 to include the contribution to international development in its annual assessment process.*

Our response

We agree that a Framework should be developed that includes not only the NHS, but also all departments of health in the UK, arm's length bodies, and UK healthcare training institutions. The IMG-GH will agree the Framework. We believe that the Framework will be important in clearly setting out government policy, legitimising activity, consolidating guidance and publicising good practice.

The Framework will be updated periodically. We anticipate that the first version will include:

- The importance of international activities being of mutual benefit, but primarily a **benefit to developing countries**
- The importance that such work is **coherent** with developing country health policy and planning
- The importance of activities being **evidence based** – updated as new evidence emerges
- The benefits of NHS and other engagement being well **coordinated** and strategic
- Government recognition that NHS and other participation in international development is legitimate and part of the **UK Government's overall commitment** to scaling up international development ⁶
- **Existing policy**, guidance and advice (England, Wales, Scotland and Northern Ireland); NHS and international development⁷ – i.e. clarity of 'rules and regulations'
- Principles and good practice for **individuals**
- Principles and good practice for **employers**
- Principles and good practice for **implementing agencies**
- Policy, as it applies to England – the Framework will be facilitative, supporting and encouraging involvement. It will also refer to existing policy in Wales, and the Scottish and Northern Ireland positions
- **UK architecture** to support NHS and others' involvement in international work
- Funding streams that NHS and others agencies can apply to.

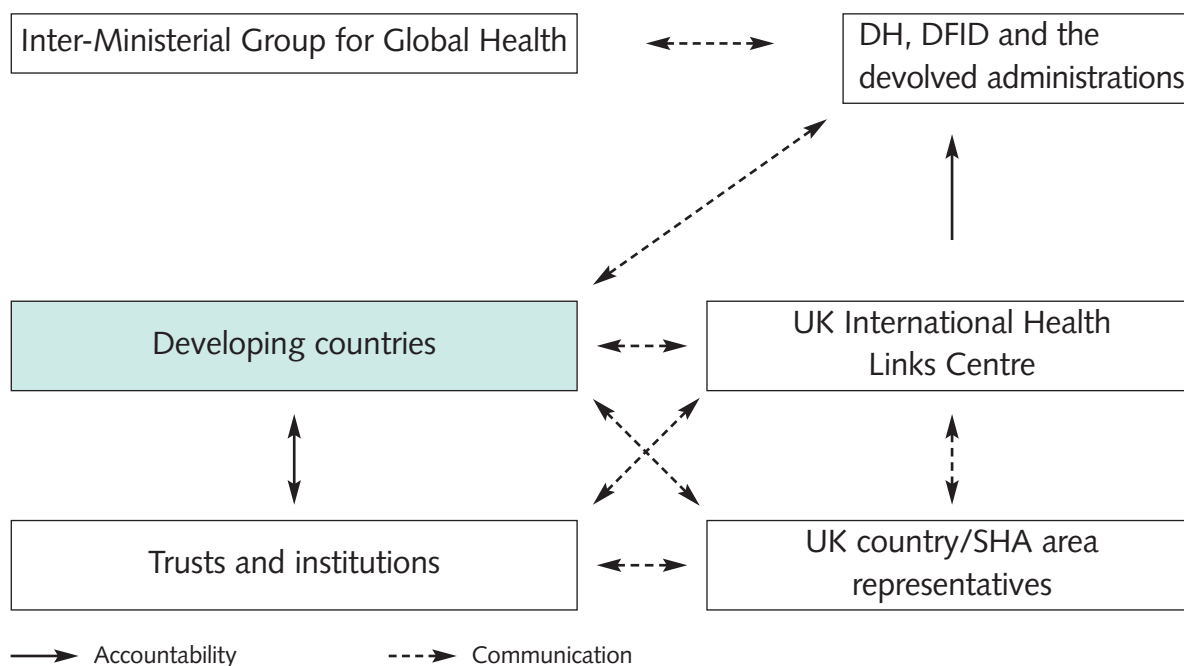
⁶ The UK's G8 presidency in 2005 highlighted for many UK citizens the need for the UK to do more and their own desire to do more. The Government would not therefore want to put in place barriers to UK institutions (health or otherwise) undertaking effective development activities.

⁷ For example, strategic in nature, harmonising with others, aligning with the country's own policies and plans, responding to assessed needs, avoiding duplication.

The *International Humanitarian and Health Work: Toolkit to Support Good Practice* will be subsumed within the Framework.⁸ As there has not been an evaluation of the Toolkit, we will do this before the Framework is developed, as well as evaluating the impact of recently issued guidance from the Welsh Assembly and Scottish Executive (Annexes 3 and 4).⁹

The UK architecture to support strengthening health capacity in developing countries

Clarifying and, where necessary, strengthening the role and responsibilities of different agencies in the UK is important if we are to maximise the effectiveness of partnerships, share information and reduce duplication. Below is a diagram of how we envisage the UK could better support this work. It builds on the new IMG-GH described in our response to Recommendation 1 of the Crisp Report.



The UK International Health Links Centre is described in our response to Recommendation 3.

8 DH (2003) *International Humanitarian and Health Work: Toolkit to Support Good Practice*; www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4102935

9 Welsh Assembly Government (2006) *NHS Wales Health Links with Sub-Saharan Africa and other Developing Health Systems*, Welsh Health Circular 070; Scottish Executive (2005) *Scottish Executive International Development Policy*.

A network of strategic health authority area individuals

We consider that a network of senior individuals covering an SHA area in England, and an individual covering each of the other three countries in the UK, could be useful in contributing to the coordination of international development activities and the capacity in their patch.

We also recognise that the devolved administrations have already identified individuals who fulfil this role. This has sometimes been incorporated in existing roles and in some cases has been funded by the Scottish and Welsh administrations.

Such a network can:

- Scope and maintain information on international initiatives on their patch
- Act as a conduit of information to the UK International Health Links Centre described on page 21
- Encourage trusts to participate in international work and direct them to the Framework.

DH will look to identify such a network through SHA CEOs, first by consulting members of a recently disbanded group.¹⁰ Members of the network could either be retired (we understand that there are individuals who would be happy to do this voluntarily) or be employed in the NHS/DH family. We would encourage those currently employed to negotiate payment for a small proportion of their time for this work from their employer – this is important if it is to be sustainable.

Role of the Healthcare Commission

Assessment of the international involvement of NHS trusts or other bodies does not fall within the Healthcare Commission's (HCC's) mandate, and would not be an appropriate role given its future working model. Furthermore, we do not consider that the HCC could make this area a priority for a 'one off' study in the time available for the organisation in its current form.

¹⁰ There has until recently been an informal network led by one of the UK consultants in public health, but current workload pressures mean that this group is not functioning at the moment.

In England, the Framework will be the route we use to encourage support for international activity. In Wales, the Welsh Health Circular (2006) 070 provides stronger advice.¹¹ Scotland will continue to use Chief Executive's Letters (CELs) to provide direction and guidance on international involvement.

Priority, importance and timing

The Framework is an important next step and one that will be taken forward as soon as possible. We anticipate that the Framework will be updated as and when policies and strategies are developed. Publishing the Framework electronically may therefore be the most appropriate approach and will allow for a cycle of evidence, policy, action and evaluation.

Resources

DH will fund an evaluation of the Toolkit and development of the Framework. We envisage this work going out to competitive tender.

¹¹ Paragraph 28 of the Welsh Assembly Government's Welsh Health Circular (2006) 070 (*NHS Wales Health Links with Sub-Saharan Africa and other Developing Health Systems*) says that "every NHS organisation should demonstrate its commitment to overseas links and its support of the Millennium Development Goals".

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.

Our response

We agree with the proposal to establish a 'one-stop-shop' to act as an information and knowledge manager for UK and developing country organisations. This role should be independent and external to government, and not involve project implementation or policy making.

The centre would provide an important signposting function. It would work mainly with organisations rather than individuals (although it could signpost individuals to relevant agencies, particularly during emergency responses for example).

The centre could help broker partnerships and match supply and demand. However, the pros and cons of this broader developmental role need to be further assessed.

Scotland has already developed plans for an international health coordination unit which will act as a central focal point for all international health development work from the NHS in Scotland. The centre will liaise closely with this unit.

The suggested title – global health partnerships centre – may be misleading, given the many existing major global initiatives and the focus on links with UK institutions.¹² We therefore suggest that the name 'UK International Health Links Centre' is used.

¹² See footnote 4.

Role of the UK International Health Links Centre

The role of the UK International Health Links Centre would include:

- Promulgating the Framework's principles and good practice (see our response to Recommendation 2)
- Working closely with colleagues in England, Wales, Northern Ireland and Scotland to identify potential overlaps or synergies
- Ensuring that developing country authorities are provided with the information to enable them to access UK partners
- Promoting best practice and ensuring that lessons developed by others feed into NHS and academic institutional links
- Facilitating links involving organisations in England, and signposting to focal points in Scotland, Wales and Northern Ireland and relevant bodies in the UK (and elsewhere)
- Providing support to organisations involved in brokering links
- Maintaining a database of UK organisations willing to act as a resource for overseas countries
- Assisting potential UK partners to make information about themselves more accessible.

Other potential roles might include:

- A resource bank of developing country health plans and those of development partners to encourage coherence and complementarity
- A signposting function to appropriate agencies for health professionals interested in voluntary or humanitarian work
- Helping partnerships assess the impact of their work
- Acting as a repository of evaluations.

Establishing the Links Centre is key to improving coherent, strategic and sustainable partnerships between developing country institutions and NHS and other UK organisations. Its work would be sited within the context of the Framework and UK development policy and would be driven by agreed objectives. There is broad support for such a centre from UK institutions, and general agreement that it could reduce transaction costs, increase dissemination of activities, facilitate and make links more transparent, and lead to a more strategic approach to partnering.

Priority, importance and timing

Establishing the Links Centre is an important step, and will be taken forward by DFID and DH as soon as possible. As a number of agencies may wish to take on the Links Centre's roles alone or as part of a consortium, any tender would be competitive and the award based on the ability to meet the agreed specification, previous experience and organisational capacity. DFID and DH will agree terms of reference and will work with others to agree the structure and relationships between the Links Centre and other stakeholders. Should an agency that is actively engaged in implementing projects bid then it will need to establish a firewall between its implementation arm and the Links Centre.

Resources

DFID will initially fund the Links Centre for two years. A further three years of funding would be dependent on a review carried out after this period. In the longer term, there may be the opportunity to support the Links Centre through subscriptions.

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.

Our response

We have reservations about supporting this recommendation on a number of grounds: the challenges of monitoring and quality control for high-tech equipment; high maintenance costs and lack of spares for older equipment; and product liability (legal risks). Similar issues – in terms of ensuring appropriate skills and qualities – concern training or employment services.

The proposed exchange is likely to contribute to one-off, ad hoc initiatives with high transaction and transport and logistic costs. The supply of material and equipment may not be in line with agreed national policy, protocols and service packages. Hospitals and other health centres in developing countries all too often bear the costs of managing inappropriate and unused donations.

A number of organisations (such as Book Aid, Computer Aid and International Health Partners), undertake a management and coordination function for both products and services. They have infrastructure in place and economies of scale that reduce transaction costs and ensure suitability of responses to requests. They are also aware of good practice guidelines – in the case of drug donations, for example, the World Health Organization (WHO) *Interagency Guidelines for Drug Donations*. The UK International Health Links Centre would signpost requesters and providers to these relevant organisations and to other providers in Europe and the rest of the world.

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 work 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.*

Our response

Arrangements to improve opportunities and remove disincentives

We agree that volunteering on development and relief programmes can make a significant and distinctive contribution to wider aid efforts. In the development sector, sustainability is crucial and thus the work of international volunteers is most effective in the context of a long-term partnership that is focused on mutually agreed objectives and approaches to improving development outcomes.¹³ The Government aims to ensure that investment in volunteering responds to the needs of developing countries.

DFID already invests significantly in volunteering schemes in developing countries through five-year Programme Partnership Agreements with VSO (£28 million annually) and smaller schemes in support of Progressio, Skillshare, Students Partnership Worldwide and International Service (total of £6.5 million annually). Other funding supports smaller organisations that place volunteers. We agree that international volunteering makes a significant and distinctive contribution to

13 See DFID (2007) *International volunteers and service delivery: beyond gap filling*.

development that complements other support such as budget and project aid. The Programme Partnership Agreements encourage a coherent and long-term approach.¹⁴

The current priorities for VSO include a focus on quality education and on HIV/AIDS. There is an emphasis on capacity building (including for teaching and training) in public health, primary healthcare and appropriate specialties. The focus is on supporting new service models and systems strengthening, and on building leadership and management skills (including in human resources, finance and information management), rather than in service delivery and direct implementation. We recognise that the number of UK health professionals currently working as volunteers in the health sector in developing countries could be greater. For VSO, the proportion involved in health-related activities is around 15%.

This coming year, 2008/09, VSO has pledged to increase its commitment to health in developing countries. It will do this by finding more flexible ways for healthcare professionals to share their skills, continuing to develop partnerships with the UK health economy, further supporting national (developing world) volunteering and looking at opportunities to develop an international advocacy strategy for health.

A key question is why there are so few volunteers. The answer, as the Crisp Report implies, is complex and multifactorial. There are concerns about: the lack of individuals with the right skills; lack of effective coordination; continuity of salaries and pensions; training, accreditation and revalidation processes; and prospects for re-entry to the same or an equally good job. Some are real barriers and some require very personal decisions to be made. Others are perceived barriers and here the Framework will clarify the key policy issues and provide clear guidance to dispel commonly held, but erroneous, views. The chapter on NHS staff and volunteering in the recently published *Healthy workplaces handbook* produced by NHS Employers also provides clarification. Below, we consider skill mix, coordination and pensions. We consider training, accreditation and revalidation in our response to Recommendation 7.

14 VSO Programme Partnership Agreements 2005–10: www.dfid.gov.uk/aboutdfid/DFIDwork/ppas/partnerprogagreements.asp

Coordination: We agree that there is a need for better coordination between volunteers and the NHS and other agencies involved in links. Models being explored include linking individual volunteers with institutional partnerships, such as the VSO component of the Malawi–Scotland link. We may wish to use some of the funding we described under Recommendation 1 to provide a ‘marketing’ strategy to highlight the benefits of volunteering to all stakeholders, including trusts and primary care trust boards.

People with the right skills: Priority areas are public health, primary healthcare, and the management and strengthening of health systems. Individuals with skills in these areas are often the most difficult to recruit. This may in part reflect the pressures on new ‘leaner’ primary care trusts, and the smaller institutional capacity of agencies to accommodate leave of absence of key staff. At the moment we do not have a solution to these problems.

Pensions: A major concern is the protection of continuity of pension contributions while the volunteer is absent overseas. Some of these are already addressed by the NHS pension regulations which allow for two options to preserve pension continuity: either short-term unpaid leave with employer and employee contributions continuing to be paid, or resignation but continued membership of the pension scheme under a Direction under the 1967 Act provided that the volunteer intends to return to the NHS.¹⁵ These provide flexibility to enable pension continuity for NHS trust employees, but staff working in primary healthcare with the status of independent contractors (like GPs) must consider the impact on their pensions if they volunteer.

For trusts to agree periods of unpaid leave they must be willing both to pay the employer pension contribution based on 14% of the salary before departure, and hold the job open for a period of up to two and a half years. There is no evidence to suggest that many trusts are unwilling to allow unpaid leave for short periods. However, anecdotal feedback suggests that, in general, this is challenging for longer periods due to the cost and recruitment difficulties of covering the post during the absence (‘backfilling’), and because it reduces flexibility of staff deployment in the present climate of workforce number limits. We recognise that, in general, longer periods of attachment (typically one to two years) for staff working on capacity building are most effective and we will ensure that the Framework encourages this

¹⁵ See Appendix 2 of the 2003 *International Humanitarian and Health Work: Toolkit to Support Good Practice*. For further details www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4102935. This guidance will be reviewed when we develop the Framework.

approach. We will encourage NHS organisations and others to participate more in global health issues by working with them to develop communication and other strategies that emphasise the links between this global contribution and corporate social responsibility.

We have agreed to pilot over three years the provision of financial support to assist with covering the pension contributions of public sector employees who volunteer in developing countries. This initiative is supported jointly by DFID, DH, DCSF and the Cabinet Office and forms part of a major push to provide opportunities for the UK public to get more personally engaged in volunteering and overseas development. The total fund will be £13 million and will be available to support volunteers who take up overseas assignments of 7 to 24 months starting between 1 April 2008 and 31 March 2011. The fund will be sufficient to meet the full pension contributions (employer and employee) for up to twice as many volunteers from the UK public service (currently serving members of the NHS or any other UK public service pension scheme) who take up a placement with any British Volunteer Agencies Liaison Group sending agency (currently VSO, Progressio, Skillshare, Students Partnership Worldwide and International Service). We will evaluate the success of this initiative at the end of the pilot before deciding on how to take things forward after this period.

Career continuity and progression: This pilot scheme puts different UK health sector professionals on a much more equal footing as far as pensions are concerned. Provided that the prospective volunteer is a currently contributing member of the NHS or any other UK public service pension scheme, and returns to that status within a set time limit (27 months including leave), the new fund will cover the full employer and employee pension contributions regardless of whether the absence is on unpaid leave or after resignation. The costs do not fall to the individual, their current employer, or any future employer.

This leaves the individual and employer, unconstrained by pensions cost issues, to consider in advance what is the best arrangement for both parties during the volunteering absence. This can be unpaid leave or resignation. There could be an agreement for a planned return at a set date to a set career path or even a particular job. Equally, there could be some more fluid arrangement (recognising that employers cannot hold particular jobs open for long periods, and individuals change and develop greatly during such a period of absence).

The new scheme is therefore fully in line with the terms and conditions of service provided by the NHS Agenda for Change, as well as provisions under junior doctors' and consultants' contracts. We will disseminate existing and emerging policies in the Framework – and we believe that this will, in part, remove some of the perceptions of barriers to volunteering currently resulting from inadequate knowledge and understanding of pension rights, career options and good employer human resources (HR) practices.

The role of strategic health authorities

The Government recognises that while the Framework can stimulate a supportive environment for volunteering, there are issues where DH in England does not have a mandate. Directing SHAs to ensure that volunteers can return to an equivalent post following a period of unpaid leave is one example.

Neither DH nor SHAs have the powers to direct NHS trusts and NHS foundation trusts to finance leave of absence or to guarantee continuity of employment. Increasingly, many provider organisations have been awarded foundation trust status and DH has no directional powers here.

Despite the above, we will, through the Framework, encourage SHAs to work with trusts to help redeploy staff in equivalent posts and this could work when and where there are workforce reconfigurations within an SHA. This could enable staff to return to an equivalent post in a neighbouring organisation if one is not available in their originating trust.

Priority, importance and timing

The Framework will encourage a more coordinated approach to volunteering and promote good workforce practice. It will clarify current guidance and regulations and disseminate this information widely. We will continue to work with SHAs, NHS Employers, and the NHS Confederation in this area.

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.*

Our response

A humanitarian database and the role of the Partnership Centre

There appears to be no enthusiasm for this recommendation from the major humanitarian agencies. We therefore believe that, while coordination could be improved, a consolidated database is not the solution. Maintenance, assessment, accreditation and monitoring would be costly and bureaucratic, and small NGOs would be unlikely to be willing to pay costs for using the service. Health workers and database users have strong organisational and brand loyalty and UK registers, held by NGOs, tend to have specific requirements and 'markets'. In addition, there is some concern that an overarching database could lead to increased transaction costs and time delays for responding agencies who prefer to keep the search facility in-house. Individual NGOs firmly believe that the assessment of technical competency is best done by individual agencies themselves.

An improved staffing response to humanitarian emergencies and longer-term development can be supported through the signposting function of the UK International Health Links Centre. This signposting would not include assessment or accreditation of individuals or agencies.

Coordination and release of staff

DFID is the lead government department for the UK's humanitarian response to natural disasters and other crises in developing countries. It operates a range of mechanisms for undertaking such responses, such as deploying humanitarian experts into the field and supporting other agencies in doing so, including the UN relief agencies, the Red Cross and NGOs. The international agencies and NGOs that specialise in deploying health professionals ensure those deployed are professionally qualified and are trained and experienced in humanitarian issues, including security. For most responses, these channels are adequate.

For some exceptionally large crises, however, for example on the scale of the Asian tsunami in 2004, it may be necessary to supplement such sources with additional health professionals, who might be drawn from the NHS. In such circumstances, DFID will consider funding DH/NHS the cost of releasing staff. This would be on a case-by-case basis, with DFID assessing the need for such staff, taking into account any request which might be made by the affected government or by WHO as leader of the international response health cluster. The expectation would be that such deployments would be infrequent, small but highly strategic. It would be helpful if DH/NHS staff identified for such deployment already had links and experience with specialist humanitarian organisations and humanitarian work in developing countries, though we recognise that this would not be essential if there were clear requirements for specific professional skills.

One of the key challenges in disasters is sharing accurate information rapidly. A lesson from recent disasters is that DH must work more closely with DFID, so that a central DH focal point can easily provide information to the NHS on what is happening on the ground in terms of needs and response. Without this, individuals and NHS agencies become frustrated, unclear as to what the UK response is, and develop their own personal response, which although well-meaning can distract from the wider international effort. In future, DH will look to provide clearer and speedier information to the NHS during these sorts of events.

Priority, importance and timing

This approach would promote a more coherent and effective NHS contribution to emergencies, both internationally and within the UK. The Framework would describe these arrangements.

Resources

The costs of signposting will be included in the running costs of the Links Centre. Costs associated with staff release will depend on the emergency and the needs on the ground. Costs of providing clear information to the NHS during disasters will be met by DH.

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.*

Our response

Recognising the value of overseas experience where appropriate

We recognise that overseas experience is valuable for UK health workers but it must fit with the needs of developing countries and follow sound development practice. Individual training and experience is likely to have the greatest benefits for recipients when it is part of a larger and long-term strategic partnership that brings institutional as well as individual benefit. We agree that better agreement is needed in terms of the contribution that overseas experience makes to training, accreditation, professional development, and revalidation, but we recognise that certain professional groups may gain more from overseas experience. We believe that it is important that colleges and postgraduate deans actively support the recognition of appropriate international experience where it meets professional training requirements.

We also agree that it is essential that medical, nursing and healthcare schools ensure that work experience and training placements are equally beneficial to the developing country concerned. For students, there may be additional ethical issues that need to be taken into account.¹⁶ We will ensure that good practice in this

¹⁶ Banatvala N, Doyal L (1998) Knowing when to say “no” on the student elective. *BMJ* 316:1404–5.

respect is included in the Framework – and widely disseminated. It will require substantial effort on the part of **all** employers and organisations that support the training, development and regulation of health professionals, to better coordinate and rationalise current practice.

The Framework will lay down the principles of what constitutes effective development work and the UK International Health Links Centre will help bring greater coherence in this area. The Framework will include existing guidance for NHS and DH employees who wish to negotiate leave of absence with their employers. We will also seek the assistance of NHS employers to disseminate advice to workforce managers.

The role of the Postgraduate Medical Education and Training Board

The four UK health departments have published *A Guide to Postgraduate Specialty Training in the UK* (also known as the 'Gold Guide').¹⁷ This document provides the framework for the new postgraduate specialty training programmes (including general practice) commencing in August 2007.

PMETB is the regulator for postgraduate medical education and training in the UK. It has a specific mandate: awarding a certificate of completion of training (CCT) to UK doctors. During this period of postgraduate training, PMETB can approve overseas placements that can count towards the CCT provided they are agreed by PMETB in advance. This requires postgraduates to be proactive in identifying or arranging such placements with the approval of their postgraduate dean. Doctors need to enrol with their relevant college or faculty and ensure that their assessments for all training posts that are to count towards their CCT programme are lodged with them.

Although the colleges have no responsibility for approving posts and programmes for the CCT award, they do have a role in determining whether the training is completed successfully and was relevant to the CCT curriculum requirements. Once the doctor has completed their postgraduate training, the relevant college or faculty makes a recommendation to PMETB, with the relevant training details, as to whether it should grant the doctor a CCT. PMETB then reviews the evidence and makes the final decision, awards the CCT and informs the General Medical Council (GMC) that specialist registration should be granted. Clearly, if doctors undertake well-structured, supervised postgraduate training that is agreed in advance, it can count as accredited CCT training.

¹⁷ www.pmetb.org.uk

The Framework and any revised Toolkit will set out the position and opportunities for each specialty. We will work with others to ensure that the position on what counts as recognised training overseas for each specialty, and the arrangements for assessment, is clear. We would not expect all specialties to have exactly the same criteria or overseas training networks as different medical and surgical specialties have different training requirements. In general, the UK departments of health and medical schools are not directly involved in the CCT process. SHAs as funding bodies will also need to recognise the benefits of such placements.

There is nothing to prevent a qualified doctor who is not on the CCT training programme from working overseas (either directly or through an international NGO or academic unit) provided they are legally allowed to practise in that country. Individuals should check regulatory requirements in individual countries and anyone offering clinical service delivery in a developing country health service should register with the country's medical or nursing council.

In addition, with the prior agreement of the postgraduate dean, doctors in training may take one year 'out of programme for clinical attachment' overseas working in a capacity which does not contribute to their formal training and can still retain their training number and return to training afterwards. Rarely, this may be extended to two years with advance agreement.

On return they will not be eligible for award of a CCT but can apply for a certificate of equivalence to CCT standards, which enables them to gain GMC GP or specialist registration in the same way as CCT holders. They would need to keep evidence of their clinical practice to satisfy PMETB through their documentary evidence that they meet CCT standards.

Education, training and regulatory issues

The White Paper *Trust, Assurance and Safety* was published in February 2007.¹⁸

The paper sets out a programme of reform to the UK's system for the regulation of health professionals, based on consultation through two reviews of professional regulation that were published in 2006.¹⁹ The White Paper is clear that systems will need to be sufficiently flexible to allow healthcare professionals working overseas or engaged in overseas activities not to be excluded by this process.

A number of working groups and steering groups are now being set up. They include groups working on revalidation and regulation of emerging professions.²⁰

A National Revalidation Working Group will be gathering evidence to run a pilot of the revalidation process across all professions in 2008. It is important that the systems for revalidation take into account individuals who are on short or long-term overseas assignments but wish to remain revalidated in the UK – either because they wish to return to the UK or they consider retaining UK revalidation as professionally desirable. The White Paper is clear that the best arrangements for professional regulation will come from working closely with professional bodies.

DH and DFID will engage with the National Revalidation Working Group and other relevant working and steering groups to ensure that revalidation works for individuals working overseas and what constitutes good development/relief practice for UK health professions working overseas.

All doctors wishing to practice in the UK need a license to practice issued by the GMC. Doctors working overseas will be able to maintain registration with the GMC but they need to agree with the GMC, in advance, how they can continue to meet

18 DH (2007) *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*; www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946

19 DH (2006) *Good doctors, safer patients* by the Chief Medical Officer (CMO) for England and DH (2006) *The regulation of the non-medical healthcare professions*. It is complemented by the Government's response to the recommendations of the Fifth Report of the Shipman Inquiry and to those of the Ayling, Neale and Kerr/Haslam Inquiries, *Safeguarding Patients*, which sets out a range of measures to improve and enhance clinical governance in the NHS.

20 Revalidation will consist of relicensing – a process that all healthcare professionals will have to undergo and which will be done every five years. Consultants and GPs will in addition have to undergo recertification to demonstrate that they meet the standards that apply to their particular medical specialty.

the requirements for revalidation of their license to practice in the UK. We will work with the GMC and explore mechanisms to facilitate this, for example through supporting validating overseas appraisers. We will ensure that up-to-date information is made available in the Framework.

Priority, importance and timing

Revalidation and accreditation are important issues where work is already being taken forward. We will work with those involved in revalidation and accreditation to ensure there is clear guidance and support to those wanting to work overseas.

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.*

Our response

We note that this recommendation is directed at developing countries. Nevertheless DFID's recent health strategy and the emerging Global Health Strategy outline the Government's commitment to backing country-led strategies and working in partnership with others to reach the goals laid out in these strategies.²¹

We agree that comprehensive plans should include the resources required to enable their delivery – and this includes partnerships. Many of the sorts of partnerships Lord Crisp describes will, however, be too small to be part of the poverty reduction strategy, which is an overarching multisectoral plan. However, at the health sector level, plans could include key strategic partnerships and the Government's overall policy and approach to engaging and managing partnerships.

DFID and other development partners are currently supporting the development and implementation of a number of government-led national poverty reduction plans as well as sectoral level plans such as health and education. Where we provide aid through the budget then it will be for developing country governments to decide how to use these resources. As DFID does not work in all sectors in the countries it supports, it does not always have the opportunity to engage in sectoral plans. Where our approach is more programme and project funded, then we will continue to work with government, other development partners and the local communities to identify and then respond as appropriate to their needs.

²¹ DFID (2007) *Working together for better health*, DFID Health Strategy; www.dfid.gov.uk/pubs/files/health-strategy07.pdf

Where countries are specifically looking for UK partnerships we will facilitate that process but within the context of the UK's untied aid²² policy. We will therefore not promote particular UK partnerships, but we will, where relevant at a strategic level, signpost country partners to sources of information to promote both north–south or south–south links. The UK International Health Links Centre and DFID country office could play a role here in helping countries make links with organisations.

Priority, importance and timing

Health sector plans may set out key strategic capacity development priorities where UK health institutions can and do make a contribution through the provision of technical assistance, academic and other inputs. Strategic contributions to these plans may be made, if timely and relevant, by DFID and other government departments.

²² Untied aid is official development assistance for which the associated goods and services may be fully and freely procured in substantially all countries.

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.*

Our response

Support to developing partnerships

We accept that there is need for independent capacity to initiate, support and develop well performing partnerships, and ensure that they contribute to a strategic approach in line with country policy and strategy. We have outlined our proposals for a one-stop shop (the UK International Health Links Centre) in our response to Recommendation 3.

We recognise the Tropical Health and Education Trust's (THET's) important contribution to international development and supporting health links and this has been demonstrated through recent DFID grants and additional support from DH. In addition to THET, DFID and the DCSF have respectively supported higher education links through the England-Africa Partnerships Scheme and the Development Partnerships in Higher Education (DePHE) programme, both managed by the British Council.²³ We will encourage agencies that support links to share their experience through regular meetings and via the UK International Health Links Centre.

²³ DFID centrally funds several higher education programmes including:

- higher and further education scholarships in 2006–08 (£12 million for the Commonwealth Scholarship and Fellowship Plan and £2 million for the Commonwealth Shared Scholarship Scheme each year); www.csfp-online.org/
- supporting up to 200 partnerships through the DePHE programme (£15 million for 2006–13); www.britishcouncil.org/learning-delphe.htm

The Department for Innovation, Universities and Skills (DIUS) (formerly the Department for Education and Skills) funds around 40 partnerships with higher education institutions in sub-Saharan Africa through the England-Africa Partnerships scheme (EAP) (£3 million in 2006–08); www.britishcouncil.org/learning-eap

Need for evaluation

We agree that more work is needed to build the evidence base around these partnerships. Despite many positive anecdotal reports, there is still insufficient understanding on the impact and benefit of these links on the UK and developing partners. DFID and DH are currently funding an independent evaluation of the impact of international health links. The work will build on work that THET is currently doing to evaluate its partnerships.

Our plan is to use the results of the evaluation to establish a Health Links Scheme that complements the existing DelpHE and community links schemes. We anticipate that this would work as a challenge fund, providing support over three years to establish and develop such links with developing country partners.

Priority, importance and timing

We expect the evaluation to be completed by mid-2008. As well as impact assessment, the study will look at models of support and funding. We will use the results of the evaluation to determine how we fund the health links scheme in the future.

Resources

We will provide up to £1.25 million annually over the CSR period for the Health Links Scheme.

Recommendation 10

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

Our response

DFID and DH have met with a number of the arm's length bodies since the publication of Lord Crisp's report. These arm's length bodies have the potential to add value to development efforts, but as we stress throughout, activities need to build on existing work and the needs of developing countries.

There are examples where arm's length bodies already contribute to or are considering contributing to international development. The Health Protection Agency (HPA), in particular, has the potential to do more. International communicable disease and control (surveillance, outbreak response, research and development) is, for example, a legitimate and complementary part of domestic disease control. Similarly, the Medicines and Healthcare products Regulatory Agency can contribute to supporting government's access to medicines agenda. The National Institute for Health and Clinical Excellence (NICE) can help poor countries develop tools to maximise the effectiveness of scarce resources. We are aware that staff from agencies such as these can make significant contributions to the work of agencies such as WHO and partners in developing countries.

We will work with the arm's length bodies to identify innovative approaches to develop their international activity. We will also work with the arm's length bodies to provide clear messages on what they are able to provide, so development partners and the UK Links Centre can communicate what advice and expertise is available.

Priority, importance and timing

Over the next year, DFID and DH will continue to explore opportunities where arm's length bodies can add value to international development. In the first instance, we will look at opportunities to help the HPA strengthen their strategic approach to international health. We are taking this forward through the emerging Global Health Strategy.

Resources

We do not envisage any costs over and above normal operational costs for continuing these discussions. Any additional support for HPA would be budgeted in the Global Health Strategy. Support for other arm's length bodies will depend on further discussions.

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.*

Our response

Codes of practice

We have used codes of practice for several years and the UK was the first developed country to introduce a code of practice for the international recruitment of healthcare professionals. This work has highlighted the need to protect fragile health economies from inappropriate recruitment by more developed countries.

More important than codes of practice is training sufficient health workers in developed countries to ensure that recruitment from developing countries is no longer needed. Toughening up on work permit requirements also helps – but of course can have a downside in restricting genuine opportunities for training. In addition, it is crucial that we help developing countries provide the environment that encourages their healthcare workers to stay in their own country – and, particularly, remain in the health sector.

As part of the NHS Plan 2000, we have invested substantially in increased training, and the UK now trains all the healthcare professionals it needs. The need for international recruitment has all but ceased.

DFID recently commissioned a review of the effectiveness of the 2004 DH *Code of Practice* (2004), a stronger version of the original 2001 Code.²⁴ Registration and work permit data suggest that fewer international health professionals are being absorbed by the UK health labour market in recent years, but there are no clear long-term patterns in the trends in inflow of health professionals from countries both

²⁴ Buchan J, McPake B (2007) *The Impact of the Department of Health England Code of Practice on International Recruitment*.

included and not included in the Code's list of developing countries. Overall, the study was inconclusive about the impact of the Code of Practice on developing countries, in large part because by the time the Code was in place, active recruitment to the NHS from overseas had significantly reduced.

Nevertheless, we do see some merit in the political signals that such codes generate. If carefully formulated, multilateral codes may help other developed countries promulgate policies that reduce their need to recruit from developing countries. We have been working, with others, on a European Union (EU) Code of Conduct. Multi-state codes of conduct, such as this and the Commonwealth Code, can, however, be a challenge, as countries have diverse health systems and differing concepts of ethical recruitment.²⁵ A plethora of codes can also result in an individual country having to respond to a range of ethical recruitment policies, standards and practices.

A way of overcoming this would be to have one global code of practice. DH is part of the Health Workers Global Policy Advisory Council, and one of its objectives is to produce a global code of practice on the migration of healthcare workers for the 2008 World Health Assembly.²⁶

Training, work experience and exchange programmes in the UK

We are cautious about scaling up training, work experience and exchange programmes as part of our mainstream international development policy, without significant evidence of their benefits. While we recognise that UK-based training and work experience is perceived by many as desirable, it has not always been appropriate to the needs of individuals or the health delivery system of the individual's own country. We also have concerns about its cost-effectiveness and its contribution to outward migration. In many cases, the money used on these often very expensive initiatives is better used for in-country training, including distance learning.

Entry for UK-based training in the health and development sectors is subject to UK immigration regulations, and particularly the new points-based system. Those wishing to host partnership and training schemes in the UK may be affected by new regulations for the accreditation and registration of approved sponsors, expected to

²⁵ The Commonwealth Code of Conduct is an example of a code that we did not endorse, as we believed it made commitments that could not be fulfilled. Only 21 of 54 countries have signed up to it.

²⁶ Initiative sponsored by WHO, the Global Workforce Alliance, and Realizing Rights – the Ethical Globalization Initiative. Its first meeting was held in May 2007.

be in place by 2008. Changes introduced by the Home Office on 6 February 2008 will impose a condition on new migrants applying through the Tier 1 arrangements, prohibiting them from taking up employment as a doctor in training unless there is no suitable UK or European Economic Area (EEA) applicant. DH is consulting on whether to impose such a condition on existing migrants.

DH will continue to work with the Border and Immigration Agency, DFID, the Foreign and Commonwealth Office (FCO) and the Royal Colleges to examine options for a fair and effective system that could enable graduate doctors outside the EEA, including developing countries, to come to the UK for periods of further training. This will build on the opportunities already available through the Medical Training Initiative.

In addition, on the occasions where UK-based training is needed, we will continue to provide opportunities by funding the Commonwealth Scholarship and Fellowship Plan (managed by the Commonwealth Scholarship Commission) and DelpHE. Our funding to the Medical Research Council (MRC) and to the Wellcome Trust enables these organisations to run research fellowships. It is crucial these training and capacity building initiatives clearly contribute to longer-term institutional and country plans. We will ask the Links Centre to map UK training initiatives. We are likely to evaluate the effectiveness of these training initiatives in future.

Priority, importance and timing

Our work on developing a multilateral code(s) of conduct with others will continue during 2008. We will ask the Links Centre to maintain a list of UK training opportunities. We will continue to collect evidence and evaluate the value of short-term training attachments.

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.*

Our response

Enabling migrants to return home

Highly complex issues, such as immigration rules, discrimination and personal safety, need detailed consideration for diaspora engagement in international development – in addition to local workforce issues both in the UK and overseas.

The 2006 White Paper on international development made a commitment to explore options for enabling health workers to return to their countries of origin without it affecting their residency status in the UK. Those who do not have permanent residence in the UK may face restrictions on the amount of time they are able to spend out of the country. DFID has been working with other government departments to explore some of these issues in more depth. This includes consulting on whether short periods of voluntary service in a developing country may count towards the 'civic duty' element of the progression to UK citizenship.

In the meantime, DFID will further assess the evidence that diaspora groups are looking for opportunities to volunteer and the blockages to their return. At the moment our view is that where members of diaspora wish to work overseas, they should use existing channels – making arrangements with trusts and others locally, either in terms of setting up specific partnerships or arranging paid or unpaid leave to work with international agencies or organisations in their country of origin. For example, organisations such as the International Organisation for Migration are piloting schemes to allow skilled members of the diaspora to return for short periods to work in specific sectors, including the health sector. We will look at what lessons can be learnt from this work. We will also continue to learn from work being done

by VSO, Africa Recruit, the Global Workforce Alliance and others in deploying volunteers from the diaspora. Further lessons for successful diaspora volunteering will be drawn from a scheme DFID will launch later this year to enable members of the diaspora to volunteer in developing countries in a wide range of sectors. DFID will also launch a scheme to link communities in the UK with those in developing countries.

NHS service scholarship

We do not agree that a new programme is required. DFID already supports the Commonwealth Scholarship and Fellowship Plan, which includes awards in the health sector. Recent evaluations of the Commonwealth scheme are positive – especially when professional development is done in country or through distance learning, and that training is relevant to country needs and is part of broader capacity building. DFID will explore extending the mandate of the Commonwealth Scholarship Commission to include non-Commonwealth countries, although this would require additional funding. The new DFID-funded DelpHE scheme is designed to support partnerships between higher education institutions in the UK and overseas.²⁷ DFID is making £15 million available for DelpHE over seven years. Under the scheme, any one of 25 developing countries can apply for partnerships with a developed country (UK or any other). We will ensure this is marketed through the UK International Health Links Centre.

The UK also supports WHO, and WHO runs a fellowship programme. Under the WHO scheme, people from developing countries can apply to receive training overseas, providing applicants have their own government's support. Under this scheme, the training should not be available in their home country.

²⁷ See footnote 23.

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, are able to enter the country.*

Our response

We recognise the role that health workers from overseas have played and continue to play in the UK health service. However, this has been part of a general international trend towards greater employment mobility, which exists across many professions, and we are by no means unique in being a global employer.

However, we agree that as part of the UK-wide commitment to development (and in line with World Health Assembly Resolution WHA 57.19 on the international migration of health personnel), government and other sectors should, wherever possible, support international efforts to scale up the education, training and employment of health workers in developing countries in line with good development practice. While DFID leads on this internationally, other government departments and bodies, and non-governmental agencies (such as academic bodies, the private sector and NGOs) can also make substantial contributions. We anticipate non-government sectors will be planning how to take forward Lord Crisp's recommendations that are relevant to them.

Supporting international efforts to scale up education, training and employment of health workers in developing countries

Recruitment, training and retention of health workers are complex issues, and there is no single intervention or quick win that will solve any country's health workforce crisis. Human resource capacity building at country level needs to be part of wider health sector development. Nationally led health workforce strategies must be linked to broader macroeconomic, public sector and civil service reforms. The emphasis must be holistic, encompassing planning, recruitment, retention and deployment (by, for example, task shifting and optimising the role of community health workers), all in the context of wider governance and public sector reforms. The Global Health Workforce Alliance has recently launched, in Kampala, an action plan for countries to take forward comprehensive plans to address the health workforce crisis. DFID's response will be guided by this work.

Increasingly, DFID support is being delivered with flexible, longer-term commitments which mean that countries can make long-term plans to invest in their health and education workforces. Financial commitments and policy engagement are designed to support national poverty reduction and sectoral strategies such as health, wider public sector workforce issues, and assistance for governance and public sector reforms. DFID is allocating funding to human resources for health at country level when it is part of a government's wider health plan. We are doing this in Malawi (through a £55 million six-year emergency human resources programme), in Nigeria, Kenya and Somaliland (by providing technical assistance to human resource strategies), and in Sierra Leone, Zimbabwe and Uganda (through project support to train health workers and to develop institutional capacity).

In addition to the above, we have been making a number of strategic contributions to international efforts to strengthen the health workforce capacity in poor countries:

- A £1 million contribution over two years to the new Global Health Workforce Alliance, a partnership bringing together a wide range of players dedicated to identifying and implementing solutions to the workforce crisis
- Providing a UK government senior civil servant as director of the Education and Training Taskforce of the Global Health Workforce Alliance
- Providing a significant input to the Global Health Worker Policy Advisory Council, set up in 2007, to provide policy advice on effective responses to health worker migration, implementing World Health Assembly resolutions on workforce migration, and drafting a global code of practice

- Working with the World Bank, WHO, the EU's Programme for Action on Human Resources for Health, USAID and the US President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, TB and Malaria, the Gates Foundation to improve coordination and programming decisions, together with the Africa Union, the New Partnership for Africa's Development (NEPAD) and country governments
- The health systems strengthening that is central to the International Health Partnership (IHP) Initiative²⁸
- The UK currently chairs the Commonwealth Health Ministers Steering Committee for Nursing and Midwifery. This helps strengthen nursing and midwifery in Commonwealth countries using tools such as regional workshops, producing practical resource materials and addressing issues such as recruitment and retention.

Lord Crisp highlights five specific areas for UK attention:

- 1 *Bringing leaders in health, education and development together with the relevant government departments to plan jointly*
We will take this forward through the Global Health Strategy.
- 2 *Identifying the areas where the UK could make the most impact and the organisations and approaches that would be the most effective*
Throughout this response we have identified areas where we can make the biggest impact and we have described the rationale for using the approaches we have outlined.
- 3 *Reviewing existing training, scholarship and partnership programmes and enhancing them as appropriate*
This is described in our response to Recommendation 12.
- 4 *Considering the incentives for UK organisations to work with trainees in the UK and abroad and amending them as appropriate*
This is described in our response to Recommendation 7.
- 5 *Ensuring that immigration arrangements allow for trainees and those seeking work experience in the UK, who have a suitable sponsor, are able to enter the country*
This is described in our response to Recommendation 11.

²⁸ The IHP is a specific deliverable under the International Poverty Reduction Public Service Delivery Agreement (PSA). DFID is the lead government department for this.

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.*

Our response

We agree that the UK and others should give increased emphasis to seeing how ICT and other new technologies can be used to improve the health of poor people and health systems in developing countries, including supporting training and development of health professionals and facilitating remote diagnosis and clinical functions. It is important that ICT is approached from a multisectoral viewpoint and that enhancing provision of ICT is based on needs rather than driven by technology.

There are a wide range of innovative programmes and projects in digital technology, but there seems to be little coordination or strategic overview. No one has the complete picture of activities. In line with our response to Lord Crisp's recommendations, any new work in this area should complement and not duplicate existing activities.

DFID funds a number of research programmes on the use of ICTs in developing countries, including in the health sector. For example, DFID funds the Canadian International Development Research Centre to look at effective uses of ICT to empower the poor in Africa and Asia. The programme has a focus on southern-led research and includes research into ICTs, the capacity building of ICT researchers and users of ICT research, including policy makers, and the effective communication of research outcomes.²⁹ We give further examples of initiatives in our response to Recommendation 16.

²⁹ More details about the project can be found at www.research4development.info/projectsAndProgrammes.asp?ProjectID=60422

The Program for Appropriate Technology in Health (PATH) aims to advance appropriate technologies as well as strengthen health systems. It works through a number of offices in developing countries. There are UK-based organisations working in this area too. Practical Action aims to help eradicate poverty in developing countries by developing and using technologies, and by demonstrating results, sharing knowledge and influencing others.³⁰ Healthlink Worldwide provides expertise in communication, knowledge management and learning. It works with organisations and institutions at all levels from local and national NGOs to national and international decision-making bodies. Part of their work is in the use of ICT for development.³¹ HealthUnlimited works with communities, service providers, policy makers and donors in difficult environments to secure access to effective primary health care for marginalised people affected by conflict, instability or discrimination.³² Save the Children has a number of different programmes looking at health systems strengthening in different countries.³³

Our view is that these agencies need to coordinate their work effectively and DFID will work with others to do this. But our view is that there is sufficient global capacity for the UK and other donors to work through. A new programme is not, therefore, needed.

DFID will fund a study to map out existing work in this area, identify gaps, and then set out options for future work. Government (Department for Innovation, Universities and Skills (DIUS), DFID, DH), the NHS and associated bodies, developing countries, the private sector, multilaterals and NGOs will all need to be involved. We will look to link this with the UK Collaborative on Development Sciences (UKCDS) work plan.³⁴

Priority, importance and timing

The mapping study will take place over the next year. As the contract will be competitive, we are not able to specify our estimated costs for this work.

30 www.practicalaction.org

31 www.healthlink.org.uk

32 www.healthunlimited.org

33 www.savethechildren.org

34 UKCDS was formed in 2007. It brings together the key funders and stakeholders to better coordinate development research in the UK and increase the relevance and impact of research for policy makers in poor countries. DFID, DH, DIUS, Wellcome Trust and four of the UK's research councils are its initial members; www.ukcds.org.uk

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.

Our response

The approach that Lord Crisp describes is already central to our human development research strategy. We currently invest significant amounts in the practical application of evidence, proven good practice in delivery and the systematic spread of good practice in health, both in domestic and international development arenas.

In line with Lord Crisp's recommendation, we propose to draw on domestic experience and expertise in developing the health elements of our development research strategy. The UK experience in the development and use of evidence-informed health practice and policy by DH and agencies such as NICE, the National Institute for Health Research (NIHR), and the National Institute for Innovation and Improvement (NIII) are of particular relevance. This expertise could be of particular benefit to partner countries in the developing world.

On the international front, we are already working together across government and with international partners to improve the development and delivery of evidence-informed health practice and policy in the developing world. Of particular note is our involvement in a WHO strategic review of its research activities. This work, which is being chaired by DH and receiving significant input and resource support from DFID, is aimed, in part, at improving WHO's capabilities in capturing and disseminating best evidence-informed practice among member states, particularly lower and middle income countries (LMICs). We will continue to support this review, with a particular focus on developing local research capacity, promoting health systems research and improving the delivery and use of knowledge in informing health policy and practice in the developing world.

We recognise that demonstrating results requires better evidence and better use of evidence. The 'Evidence for Action' paper that accompanied DFID's health strategy, *Working together for better health*, details the role of evidence and describes how DFID plans to improve the way evidence is generated and used in achieving better results. DFID has a strong record in supporting research and innovation and the 2006 Development White Paper commits DFID to doubling its total research spending

to £220 million per annum by 2010/11.³⁵ DFID currently allocates 40% of its research budget to health, funding multilateral and bilateral health research in policy, systems and services, and for specific diseases, as well as the development of new drugs and prevention technologies.

We do, however, recognise the need to strengthen links further between research and policy, and in particular including the way in which policy makers are informed of research findings. There is also a need to work more effectively with policy makers in developing countries on when and how to introduce new products and technologies.

The UK Collaborative on Development Sciences (UKCDS) will also wish to take this recommendation into account, as will the Global Science and Innovation Forum.³⁶

35 DFID's current research framework has four priorities: (i) sustainable agriculture, especially in Africa; (ii) 'killer diseases' and healthcare; (iii) states that work for poor people, which covers both governance and social research; and (iv) the impact of climate change on poverty, including environmental change more broadly. Details of research funded by DFID can be found on the research portal – Research4Development at www.research4development.info

36 The Global Science and Innovation Forum (GSIF) allows cross-government exchange of information and ideas to improve coordination of the UK's international science and innovation collaboration, and scans the horizon for new and emerging issues. Its members are DIUS, FCO, HM Treasury, Department for Environment, Food and Rural Affairs, DFID, DH, Home Office, UK Trade and Industry, Royal Society, British Council and Research Councils. GSIF published its strategy for *International engagement in research and development* in 2006, which includes an objective on the use of research and innovation to support international development; www.berr.gov.uk/dius/science/int/gsif/strategy_2006/page40354.html

DFID is currently developing its new research strategy, setting out priorities for the five-year period 2008/09 to 2012/13.³⁷

It is likely that this strategy will:

- Fund more research that helps partner countries build their economies. There will be more funds to develop innovative technologies, for instance to develop new drugs, vaccines and diagnostics against communicable diseases
- Put more emphasis on research that helps developing countries increase their awareness of the impact of likely global trends that will shape their development (e.g. new economic powers, climate change, new disease threats, trading opportunities)
- Increase cross-cutting research (e.g. how climate change will affect the economic and political decision making, the links between education, the economy and health)
- Increase the emphasis on how research can be used to shape decision making.

Priority, importance and timing

The consultation on DFID's research strategy took place during the second half of 2007, and a new strategy will be launched later this year.

³⁷ Details on the consultation can be found at www.dfid.gov.uk/consultations/crd/objectives.asp. The following key issues are being discussed: (i) how to build on existing research themes and address the links between them more effectively; (ii) how to improve demand for research from end-users in developing countries; (iii) how to promote more cutting-edge science that will benefit poor people; (iv) how to work more effectively to help developing countries to carry out, access and use research themselves; and (v) how make it more likely that research will be used.

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.*

Our response

The UK has an enviable degree of expertise and experience in the development of evidence-informed practice and knowledge management systems for health. The UK government already supports a wide programme of activities in this area and we agree that it is important that this work is done in collaboration with other development partners, and in the context of supporting countries' priorities and plans.

DIUS, the Department for Business, Enterprise and Regulatory Reform, DH and DFID already contribute to very significant international efforts on knowledge management and evidence-informed decision making. Examples include support to the Cochrane Collaboration Review Group on Infectious Diseases in Developing Countries, WHO's review of its research activities, the Health Metrics Network to accelerate building of country-level health information systems, the World Alliance for Patient Safety, and a number of MRC, Wellcome and other research collaborations.

As with Recommendation 15, the UKCDS will take this recommendation into account. The Global Science and Innovation Forum will also reflect on this recommendation.

We agree that making healthcare knowledge accessible to practitioners and the public is crucial and DFID supports a number of initiatives in this area:

- The PANOS research communication programme (RELAY), that disseminates research for media in developing countries
- The Global Development Network (gdnet.org), which communicates research from developing and transitional countries

- The Programme for the Enhancement of Research Information (PERI), to support capacity building in research in developing and transitional countries. It does this by strengthening production, access and dissemination of peer-reviewed and other journals in over 50 countries
- The Science and Development Network (SciDev.Net). This promulgates reliable and authoritative information in the area of science and technology
- Research Africa. This increases the access of research material and its application
- A range of web-based, electronic and print information services including the British Library for Development Studies (BLDS), the electronic development and environmental information service (ELDIS), the BRIDGE, which supports mainstreaming of gender, and ID21 which highlights a variety of research findings in easy to read language
- Research4Development, DFID's free on-line system with details of all research funded centrally by DFID
- The NEPAD strategic plan for science and technology
- The World Federation of Science Writers Joint Programme to improve the quality of science reporting worldwide
- The International Development Research Centre, which was set up to advance the role of information in development and in particular the transformative nature of information and communications technologies
- Makutano Junction, a TV drama in Kenya, Uganda and Tanzania, disseminating information in health and other areas
- The WRENmedia Research communication project, which brings together national research, advisory groups, private sector stakeholders and the media to share messages with rural populations.

One of the strengths of DFID is its in-country health advisers. These individuals work closely with policy makers, working with research and other development partners to consolidate and share new knowledge, jointly develop policy on the basis of evidence, and, where appropriate, fund local projects and activities to help countries develop their knowledge systems.

Annex 1: Assessment criteria

The UK Government's response to the *Global Health Partnerships* report draws on an assessment of each recommendation against nine criteria. The nine criteria reflect and expand on the principles on which Lord Crisp's report is based: country needs; added practical value; mutuality; scale and localness; and involvement of the NHS and partners.

This assessment informed the UK Government's view on whether, at what scale and over what time period each recommendation should be taken forward.

The assessment criteria are:

- 1 Coherence:** Would the recommended actions contribute to a coherent, systematic and strategic approach in the UK and in developing countries?
- 2 Country ownership and needs:** Can the actions be aligned with country-led strategies and needs and support wider public reform policy? Will the actions ensure that inputs are appropriate to local working conditions and health policies? Does the UK health sector have capacity and comparative advantage in provision of the required expertise and knowledge?
- 3 UK development policy:** Are the actions in line with current UK aid effectiveness policy (poverty focus, budget and sector support, untied aid etc.)?
- 4 Feasibility:** What is the likely feasibility of rolling out the recommendation in the current policy environment (e.g. political, institutional, operational issues)?
- 5 Impact and added value:** Is the action based on knowledge of what works?
- 6** Would the actions add value to and increase the effectiveness of existing efforts and reduce potential duplication?
- 7 Costs and value for money:** What are the budget and cost implications (including opportunity costs)? Who bears the costs? Are the expected benefits commensurate with the likely costs for UK agencies and country partners?
- 8 Sustainability:** Can the actions be predictably funded over time? How would they be funded?
- 9 UK needs:** Does the action meet UK needs with respect to human resource requirements (workforce and career development needs)?

Annex 2: List of organisations and agencies consulted

Government
Department of Health
Department for Children, Schools and Families
Department for International Development
Department for Business, Enterprise and Regulatory Reform
Office for Science and Innovation, Department for Innovation, Universities and Skills
Foreign and Commonwealth Office
HM Treasury
Home Office
Scottish Executive
Welsh Assembly Government
Northern Ireland Office
US Department of Health and Human Services

NHS, national and international professional bodies
British Medical Association
General Medical Council
Faculty of Public Health
Fogarty International Center, National Institutes of Health, USA
Healthcare Commission
Health and Social Care Information Centre
Health Protection Agency
Information Centre for Health and Social Care
Institute for Innovation and Improvement
Medicines and Healthcare products Regulatory Agency
Medical Schools Council
National Institute for Health and Clinical Excellence
Monitor
NHS Confederation
NHS Direct
NHS Employers
Postgraduate Medical Education and Training Board
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal Colleges International Forum
Public Health Foundation of India
School of Public Health, The Chinese University of Hong Kong
NHS SHAs, trusts and foundation trusts
Office of the Strategic Health Authorities
East SHA
King's College Hospital
Northumbria Healthcare NHS Foundation Trust
Sheffield Healthcare
Yorkshire and the Humber SHA

Non-governmental organisations and others
AfricaRecruit
British Council
Center for Global Development, USA
Cisco
Commonwealth Scholarship Commission
Doctors.net
Global Health Council, USA
Global Healthcare Information Network
Health for All Network
Health Unlimited
International Health Partners
Judge Business School, University of Cambridge
Médecins Sans Frontières
Merlin
Oxfam
Partnerships in Health Information
RedR-IHE
PATH (Program for Appropriate Technology in Health), USA
Skillshare International
Tropical Health and Education Trust, including THET link partners in the Ministries of Health in Ghana, Uganda and Malawi
Universities UK
Voluntary Services Overseas

Annex 3: International development policy in Wales

Policy

Welsh Health Circular (2006) 070 was issued as part of the launch of the Welsh International Sustainable Development Framework in October 2006. 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.

The circular provided information, details of available funding and guidance on the Welsh Assembly Government's policy for links between health services in Wales and health services in Sub-Saharan Africa and elsewhere in the South of the world. It was circulated for action to NHS Wales' organisations, along with the university schools, who were urged to link with overseas partners including health providers, universities, trainers, NGOs, international health organisations and governments.

Chief executives were asked to ensure that each NHS organisation demonstrated its commitment to overseas links and its support of the Millennium Development Goals within its stated goals. Chief executives and HR directors were to recognise that continuing professional development policies should allow visits, secondments, exchanges and the management of projects to be recognised as one of the options allowed to NHS employees.

Communication of policy

To communicate the policy, there was an initial circular in October 2006 to NHS organisations and an initial workshop held in October 2006. Welsh Health Circular (2006) 070 was further enhanced with a conference to promote awareness, assess progress and share good practice that was held in June 2007. A further conference is planned for June 2008 entitled 'Increasing the impact of health links'.

Funding

It was anticipated that pump-priming money to assist in setting up new and supporting developed projects would be identified from NHS HR education budgets. The principle behind this was that the NHS had 'saved' thousands of pounds' worth of training for every international recruit, and therefore an amount could be put aside to be used as pump-priming money to support international links. The amount identified and managed by NHS HR, Welsh Assembly Government was £50,000 per annum. Any request for funding has to be supported by a case identifying how the initiative supports one or more Millennium Development Goals.

Year 1 (2006/07) and Year 2 (2007/08)

Ten applications were received and eight were approved.

Year 3 (2008/09)

Twenty applications were received, with the hope of approving 15 – many of which are new initiatives.

This highlights the increasing demand on our NHS HR fund and highlights the necessity for all link organisations to supplement this funding through money-raising activities.

Current programme

Eight initiatives in 2006–08 and 15 (awaiting approval) in 2008/09 in Sub-Saharan Africa have been selected for sponsorship.

The majority focus on training activities, with some using e-learning and others incorporating activities reducing the incidence and spread of HIV/AIDS, reducing child and maternal death, increasing awareness of tropical medicine and practical experience of tropical disease, community twinning and training for an oral pathologist. Several of the initiatives build on existing links.

There is a Public Services Management Wales (PSMW)/VSO initiative that is aimed to provide short-term development placements in Africa for public sector leaders and managers.

Evaluation

Individual links carry out formal outcome/impact evaluations and every six months are required to report on activities undertaken to NHS HR, Welsh Assembly Government as a requirement of the sponsorship received.

Annex 4: International development policy and fund, Scotland

Scottish ministers launched Scotland's international development policy in 2005, outlining its main priorities, approach and funding arrangements.

In May 2007, a new government was elected to office in Scotland. The Scottish Government launched a review of its policy to seek the views of stakeholders.

As defined in 2005, the international development policy aims to support:

- NGOs to build their capacity for better engagement in a two-way exchange of knowledge and expertise
- Assistance during international crises
- Local awareness of international development issues.

The policy identified the following geographical priority areas:

- Sub-Saharan Africa, with particular emphasis on Malawi
- Tsunami-affected regions
- For 2006 only, the Pakistan earthquake zone.

The policy defined priorities in the fields of education, health (including HIV/AIDS and water), civil society development and governance.

The new Scottish Government has confirmed its commitment to supporting international development by continuing to work with DFID to further the common aim of tackling the underlying causes of world poverty, and contributing to the targets set out in the Millennium Development Goals. The Government has increased the International Development Fund to £9 million for the duration of the Parliament to assist Scotland's NGOs and institutions in ensuring that this support meets the needs of those in greatest need.

International Development Fund

Policy implementation is supported by an International Development Fund. The fund has been open to Scotland-based organisations that carry out work that reflects the priority areas. The fund encourages work that is consistent with the developing countries policy and planning, effectively meets locally identified needs and demonstrates positive outcomes that will be sustainable beyond the life of the project.

The International Development Fund is a single 'pot' that has been distributed in different ways. Decisions as to future distribution mechanisms have yet to be announced. All international development work is financed through this fund and supplemented by external sponsorship. It is currently managed by the International Division in the Scottish Government's Europe, External Affairs and Culture Directorate.

Scotland Malawi Partnership

The Malawi initiative is based on a Government-to-Government cooperation agreement drawn up in 2005 between the former First Minister of Scotland and the President of the Republic of Malawi, Dr Bingu wa Mutharika. The cooperation agreement covers four main strands: health; education; sustainable economic development; and civic governance and society. The Scottish Government has committed to maintaining its relationship with Malawi and has ring-fenced a minimum of £3 million per annum.

An action plan for delivering the health strand of the cooperation agreement was drafted in November 2005 and ratified in November 2006, agreed under broad headings mainly connected with the workforce crisis. It complements Malawi's Emergency Human Resource Programme, supported by DFID, and aims to support:

- Training and staff development – through building the capacity of medical and other training institutions to increase their numbers and quality of students, and continuing professional development through skill-sharing on site, with special emphasis on maternal health
- Health service delivery – through supporting practitioners on site, and strengthening district hospital and health facility systems (such as networks of care, communication pathways, essential competencies, resources and equipment) to enable facilities to deliver the essential health package
- Learning through sharing – a mutually beneficial partnership in which Scotland's healthcare will improve through shared experience and new learning.

To date, the agreement with Malawi has not had a dedicated budget – all providers have to bid into the challenge fund. Bidders have to comply with criteria and to produce regular reports of their activities. Bidders are encouraged to bid within a particular stream, and the nature of their contribution is negotiated with their partners in Malawi.

Over 60 health projects have been funded in Malawi, including curriculum development support and ongoing new practitioner courses, offered from Bell Nursing College to Kamuzu College of Nursing in Malawi. E-learning initiatives to enhance staff development, and teaching and training resources for students, have been offered at the College of Medicine, encompassing psychiatry, midwifery, pathology, palliative care and surgical training modules delivered in college and on-site, and nutritional and sanitation support have been provided. Senior staff from the Health Directorate in Scotland are working with Senior Ministry of Health staff in a country-wide strategic review of nursing.

VSO/NHS Scotland partnership

This agreement was motivated by the wish of VSO to establish a strategic alliance with government partners to support targeted recruitment of certain professional groups such as healthcare and teaching staff.

The numbers of volunteers coming forward did not meet demand from the developing world. Perceived barriers were that, in general, professional staff were required to resign from their post when volunteering, employee terms and conditions entitlement were lost and pensions were frozen for the duration of the placement. On return, healthcare professionals were required to reapply for posts in open competition.

In 2006, a two-year pilot (April 2006–March 2008) partnership between NHS Scotland, the Scottish Executive and VSO was developed as a solution to the perceived future employment and pension problem, linked to the alliance between Scotland and Malawi. To kick-start the partnership, the International Division agreed to fund £50,000 for two years to support NHS Scotland pension contribution costs for 20 healthcare professionals on placements in Malawi and Sub-Saharan Africa, and £50,000 towards ten delivery grants for placements in Malawi only.

The partnership is underpinned by policy and guidance and promoted through NHS Scotland through active championing and integration into internal HR communications. Before the partnership was launched by the former Minister for Health and Community Care, official guidance in the form of a Health Department Letter (HDL) was issued by the Scottish Executive to NHS Scotland in February 2006. This set out the details of the partnership, the benefits to the service and to staff and how secondments would work.

HDLs, now known as Chief Executive's Letters (CELs), act as directives on policy and implementation from the Scottish Executive. A direct action is usually called for and progress can be built into the annual performance reviews of each local health board. However, despite wide dissemination of the policy and guidance papers, the initial response was relatively small. A total of 11 people expressed interest, of which three were motivated by personal contact with the VSO lead/coordinator. A further 2,000 targeted letters were distributed in July 2006, but these generated just five enquiries.

Feedback elicited during follow-up meetings with health boards made it clear that managers had been concerned about promoting the scheme too vigorously, fearing that a high uptake would affect service delivery. On understanding the value to the NHS of working with VSO, and appreciating that VSO were aiming to attract a very small number of applicants compared to the total number of NHS employees, there was greater enthusiasm.

Activity by the boards has now resulted in a total of 360 enquiries and 64 applications (a rise of 170% during the life of the pilot). Five of these have been for short term volunteering. Seven people are presently overseas, with a further nine in the pipeline. To date, VSO has spent almost £27,000 of funds available to it. In addition, partly through the programme partnership agreement with DFID, VSO invests around £30,000 in each volunteer over two years while on placement – in subsistence, training, grants, travel costs etc.

More information about the Scottish Executive's international development policy is available at www.scotland.gov.uk/Topics/Government/International-Relations/internationaldevelopment

All of Scotland's international development health engagement is underpinned by a set of guiding principles, to ensure that work is implemented appropriately and that engagement benefits both countries.

Our engagement must:

- **Be coherent** with the country's Ministry of Health's programme of work/ health strategy
- **Focus** on supporting health systems and building capacity within the health workforce, rather than individual health unit support, as far as is appropriate and helpful
- **Be respectful** of the planned and prioritised programme for upgrading facilities within districts, and the list of essential equipment for all facilities
- **Use, develop and support existing expertise** from within the Ministry of Health and DFID offices, and facilitate regional networking
- **Recognise mutual learning** – the experience of both partners will be utilised for mutual learning.



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