Health systems strengthening in low and middle income countries: UK partnerships at the systems level

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October 2015
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**Acknowledgements**

Thank you to all of those who participated in this work, either through interviews, informal discussions and review of the report. A big thanks to the team at NICE International for project support to complete this. I’d like to particularly thank Kalipso Chalkidou, Françoise Cluzeau, and the team at NICE International, and Julia Watson, Lizzie Smith and Nadeem Hasan at DFID for regular discussion on this topic. I have not individually acknowledged those interviewed here, as interviews were anonymous.
Purpose

The overall aim of this report is to outline considerations and potential approaches for UK state sector organisations to systematically collaborate with low and middle income countries (LMICs) for health systems strengthening. The report is aimed at all of those with an interest in international technical collaborations for health systems strengthening.

Summary

Background
The Sustainable Development Goals (SDGs) puts health systems strengthening high on the global health agenda. Universal Health Coverage (UHC) is a standalone target under the health goal. The International Development Committee undertook an inquiry into the Department for International Development’s work on health systems strengthening, and recommended establishment of a clear strategy for how the UK government should work in partnership with the National Health Service to support overseas health systems. There has been a great deal of work in this area to date, predominantly focused on voluntary activity. Whilst recognising the value of voluntary work, this report seeks to outline considerations and approaches for sustained partnerships at the policy or system-level, in response to demand from low and middle income countries.

Methods
Twenty four key informants were interviewed from a variety of organisations including the National Health Service, central government departments and executive agencies, non-governmental organisations, royal colleges, and academic institutions. Responses have been anonymised. A small group informal meeting was held to discuss and refine the findings. The report presents views on the current gaps with systems-level partnerships, possible mechanisms for such partnerships between UK state sector organisations and low and middle income countries, and the likely risks and challenges.

Findings
The need to develop an overarching vision, strategy and UK offer for health systems strengthening partnerships and collaborations was highlighted. A number of considerations were discussed, including the nature of the activity, geographical remit and working in middle income countries, accessing sustained funding, and measuring results. The most consistently raised issue was coordination between UK state sector organisations, although fora have been developed to try to address this.

In order for the UK to cohesively respond to demand, where additional mechanisms were felt to be needed, six main approaches were outlined: a consortium of state sector institutions; development of a centre with cross-cutting expertise; a managed fund for systems-level
partnerships; a social enterprise approach; a regional approach harnessing academic health science networks; or provision of small development assistance budgets for individual organisations. The risks associated with each approach need to be carefully considered.

**Conclusions**

Much future action depends on the overarching vision and strategy for the UK approach to health systems strengthening. The Department for International Development is developing a framework for health systems strengthening. More work is needed to assess which approach is best placed to respond to demand, and indeed more than one may be appropriate, or a combination of approaches. This needs to be based on an empirical assessment of the nature of demand from low and middle income countries for collaboration. Realisation of ambitions for increased and more sustained technical collaboration will require concerted political commitment and action at the highest level, across government, and a more coherent approach by the UK to development issues in middle income countries. What is clear is that there are individuals in the UK health system with a lot of enthusiasm, commitment, thinking and will to move this forwards.
**Background**

The Sustainable Development Goals (SDGs) puts health systems strengthening high on the global health agenda. Universal Health Coverage (UHC) is a standalone target under the health goal. At the same time the global political landscape is shifting with implications for the nature of development assistance, providing opportunities for more collaborative working in many countries, including technical cooperation to support the development of sustainable institutions, strengthen governance and tackle corruption.

The increasing prominence of "Global Health Security", and the recent Ebola epidemic in West Africa are additional global drivers for UHC and health systems strengthening - recognising that strong health systems are key to preventing and responding to health threats.(1)

The UK health system was ranked first out of 11 high income countries examined by the Commonwealth Fund in their most recent assessment.(2) A recent editorial in The Lancet stated that “[t]he UK’s experience with the NHS should make advocacy for universal health coverage one of our greatest comparative advantages. Instead, the UK is a lacklustre bystander in one of the most significant movements of our times.”(3)

The International Development Committee (IDC) inquiry on Health Systems Strengthening in 2014 recommended the Department for International Development (DFID) to establish a clear strategy for how the UK government should work in partnership with the National Health Service (NHS) to support overseas health systems.(4) In response, DFID is currently developing a framework from health systems strengthening that will encompass this recommendation.

The IDC recommendation for future partnering with the NHS extends beyond using expertise in direct clinical care to management and finance skills. The benefits of such partnering outlined by Chalkidou and Vega are (5):

- Combating poverty and helping countries reach universal coverage
- Global Health Diplomacy and smart power through strengthening of NHS/UK brand
- Commercial interests protected through stronger/predictable regulatory environment

This is reflected in ‘Health is Global, the cross-government global health strategy’, which outlines three main areas of action: Global health security; International development; and Trade for better health.(6) More specifically there is an outcome related to using resources to support health systems strengthening. The strategy completes in 2015.

Defining Health Systems Strengthening, and the scope of work in this area is difficult. Health systems are clearly linked to wider determinants of health, but also to wider governance
issues. Ultimately it is a complex issue that will differ in nature from context to context. For the purposes of this report, the scope of health systems will be that outlined by DFID.(7)

Initial review of some of the work to date in the area with respect to partnerships and collaboration suggested there has been a strong focus on volunteering from the NHS, particularly for clinical health professionals.(8-11) This has been supported at a high level through the framework for volunteering developed by the Department of Health (DH), the NHS and DFID.(9) The Academy of Medical Royal Colleges (AoMRC) also issued a statement in support of volunteering.(8) There are calls to incorporate global health more clearly into training programmes in the NHS, and recognise volunteering for continuing professional development.(12, 13)

The DFID Health Partnerships Scheme managed by the Tropical Health and Education Trust (THET) has a budget of £30 million, and is fostering institutional partnerships through volunteers.(10) This programme has been extended to 2017. The predominant support through this has been linking hospital providers, although the programme has also funded expenses for volunteering from more upstream institutions, such as NICE International and the Royal Colleges.

On the other end of the spectrum, Healthcare UK aims to help UK healthcare providers to do more commercially driven business overseas. Healthcare UK does not have a development focus to reach the poorest and most vulnerable – but does acknowledge the importance of ‘philanthropic’ activities.(14) Indeed, philanthropic activities could be viewed as a broader engagement tool, that could facilitate commercial engagement.(5)

This particular work will explore activity beyond volunteering, whilst recognising the important contribution of volunteering that has been highlighted in a number of reports (9-11), with further emerging evidence anticipated from the Measuring the Outcomes of Volunteering for Education (MOVE) being undertaken in the North West of England.(15) The focus of this paper is on systematic, long term dedicated partnership and technical collaboration between the UK health system and LMICs at the systems level. Prior to the election the Conservative Party manifesto also stated that “[w]e will boost partnerships between UK institutions and their counterparts in the developing world...” - indicating support from the current government for such activity.

The All-Party Parliamentary Group (APPG) for Global Health and the London School for Hygiene and Tropical Medicine (LSHTM) completed a mapping of the UK’s contribution to health globally, examining the state, academic, commercial and not-for-profit sector.(16) For the state sector, they recommended “using the range of UK expertise in health...in a more coordinated way to improve health systems across the world...”. The report highlighted the reputation of the UK health system, including the values of UHC, but also highlighted issues
such as the geographical range of UK influence, poor coordination and weak relationships between UK state sector actors, the challenges to the NHS domestically as a threat to the UK’s reputation, and the threat of immigration reform impacting on the ability to retain the best staff.

The changing nature of development assistance and the nature of partnerships as countries develop, and the increasing global momentum for universal health coverage, provide an opportunity to harness UK technical expertise for health systems strengthening. Such support would need to be driven by demand from governments in LMICs, provided according to the priorities and context in country, and sustained. (5, 17) The current challenges to the NHS resources could provide a further incentive to develop high level partnerships and collaborations. Such partnerships could also provide learning for the NHS to use in the UK, as a part of the NHS Five Year Forward View. (18, 19) However, there are potential risks and challenges that also need to be considered.
Methods

I undertook 24 key informant interviews either face to face or on the phone, and had ongoing informal discussion and technical support from 4 additional people. The interviews were with individuals from a variety of UK-based, predominantly state sector, organisations with a remit in health domestically or internationally.

Those selected for interview were from a range of organisations: the NHS, central government departments and executive agencies, non-governmental organisations, royal colleges, and academic institutions. There was a subsequent small-group meeting held with representation from DFID, DH, the Foreign and Commonwealth Office (FCO), the National Institute for Health and Care Excellence (NICE) and Public Health England (PHE) where the initial interview findings were discussed. The information presented here, based on identifying themes from the interview notes, is with great thanks to those who were interviewed and/or participated in the meeting. Those participating have not been individually acknowledged to maintain confidentiality.

Interview responses were anonymous. Interviewees were asked questions on the four following areas:

1. What knowledge and skills can the NHS [their organisation] potentially offer – areas of particular expertise? Is there an appetite to offer this? What are the gaps with current partnerships?
2. What are the possible mechanisms for partnerships with the NHS in LMICs? How could demand be channelled?
3. What are the likely risks and challenges? How could these be overcome?
4. What might be the benefits to the NHS [their organisation] of partnering for work in LMICs?

The focus of this report is on areas two and three above. Whilst the findings are presented in discrete categories, it is recognised that these issues are complex and interlinked.

There is an inherent bias as those identified were generally already engaged in international work, and the views are not stated to be representative of all those in UK state sector health institutions. In addition, the interviewees did not include any people from institutions in LMICs, so this is a UK perspective. This work is not a review of current activity internationally, which has been systematically captured by the APPG in Global Health/LSHTM work on the contribution of the UK to health globally.(16)
Findings

The findings are presented in the following areas:

1. What are the critiques of current partnerships?
2. How can we understand the demand?
3. What should be considered when responding to demand in the future?
4. What are the risks of such partnerships and collaborations?
5. What sorts of approaches could be considered to respond to demand?

1. What are the critiques of current partnerships?

There has been a lot of work developing partnerships between UK NHS and other supporting health institutions with LMICs, with dedication from a number of people to achieve this. Many respondents highlighted the progress that has been made to increase the number of partnerships and technical collaborations, with initiatives to support this, and efforts to coordinate between organisations. In order to frame the issue, however, I asked respondents to identify where the gaps may be with current partnerships.

Drivers

One issue described was the commercial drive to ‘sell’ the NHS and make money. Whilst some could see the rationale in high income countries, there was a concern that this was being prioritised over the opportunities for ‘philanthropic’ partnerships, and could call the motive of partnerships into question. This has been echoed by others, stating that there has been increasing emphasis on commercial and often short-term endeavours. The recent APPG report stated that “[s]ome interviewees highlighted a broader threat to the UK’s international reputation from the government being seen to be ‘pushing sales’ in health rather than being seen as a voice for supporting UHC and stronger health systems across the world. These conflicting messages were noted to have a knock-on effect on the UK’s reputation and foreign governments’ trust in other UK organisations such as DFID and NICE.”

A second issue described with current partnerships is that they can be supply-driven – that is, developed based on the interests of people in the UK forming partnerships, rather than on priorities in partner countries. The concern was the risk of inappropriate collaborations that were not in the interests of the partner country.

Coordination

Coordination was highlighted by the majority of people to be an ongoing issue. The current model was described as decentralised and fragmented. There were examples given by more
than one respondent about starting a partnerships to then find that other UK organisations were trying to develop partnerships in the same area. Such fragmentation can be onerous for the partner country in question.

There have been efforts to develop coordination mechanisms: the Health is Global Steering Group, the NHS International Group, the International Health Forum and the International Forum of the Academy of Medical Royal Colleges were the main ones cited. Each has a separate but overlapping remit to coordinate activity. The organisations involved also overlap, but not completely. The number of fora signal the clear recognition of the importance of coordination, but are themselves fragmented. One respondent stated that as organisations were in very different ‘stages’ or had differing agendas with respect to their international engagement there was difficulty finding common ground within these fora.

Some felt it was still early days, and given the difficulty of coordinating activity it will take some time to address this issue, and the fora that have already been developed should continue to be used, otherwise risking the creation of a further overlapping structure. Other respondents felt that the coordination mechanisms in place were too loose and decentralised, and too broad in their agenda to focus on health systems strengthening.

Activity

Predominant activity for partnerships between UK institutions with LMICs was described as generally at the provider-level rather than policy or systems-level, and disconnected from UK bilateral health programmes. Some interviewees stated there were distorted incentives from methods to measure outcomes resulting in relatively vertical or piecemeal initiatives. In addition, whilst some felt that volunteerism was a good model, others felt that the voluntary nature of activity posed difficulty for sustained, high-level, technical cooperation that was systems-strengthening. Indeed, there was concern that partnership activity was generally the result of committed individuals, rather than high level organisational commitment. Public health and primary care were felt to be underrepresented generally.

Capacity

Issues related to UK capacity fell into three main areas: the domestic (UK) capacity to respond to requests for systems-level partnerships and technical cooperation; the capacity for longer term partnerships and sustaining change, including both the availability of and capacity to access funding for longer term projects; and the capacity to systematise learning from other settings to the UK health system.
2. How can we understand the demand?

The basis of this work is that partnerships would be conducted in response to demand from LMICs. This generated two main further discussions. Demand is not equal to need. It does, however, indicate a political/policy priority on the part of the potential partner country, and what other countries see as particular areas to look to partner with the UK.

A further point was the need to understand the nature of demand. Several people noted that there was high demand, channelled to state, commercial and academic organisations, but that this demand was not well characterised and that there were instances where it was unclear how to respond. There was one suggestion to review previous requests (within a defined time-frame) from LMICs to FCO, DFID and DH to understand the level of demand and perceived comparative advantage of the UK system. This can guide the focus and development of a core UK offer. However, the offers are not likely to be compiled and recorded in a way that allows this - perhaps a development of a database to document such requests would help.

3. What issues should be considered when responding to demand?

General principles

The following words were used to describe the principles of partnerships and technical cooperation, and are also used in frameworks and strategy documents of some UK state sector organisations (9, 20-24): demand-driven, country-led, appropriate to context, grounded in needs assessments, recognises the political economy in the partner country, partnership principles, co-development and mutual learning, collaborative, additionality and sustainability, quality assured.

Other issues that were raised included the importance of recognising our weaknesses as well as strengths as sources of technical knowledge sharing, and to be receptive to ideas from LMICs that could be used to improve UK practice. There was also a clear sense from interviewees that this is about sharing health systems concepts, rather than advocating wholesale adoption of a system such as the NHS in its current form.

Geographical remit

Given the focus on LMICs, a question arose about the extent to which partnerships should be aligned with DFID bilateral priority countries.(25) However, the geographical reach of DFID funding is much broader than those countries, as over half of aid is channelled through
multilateral agencies which work in a much broader set of countries. As middle-income countries ‘graduate’ from UK aid, the question of how activity in middle income countries would be supported was raised, and is discussed more below (under use of ODA).

The issue of geographical coverage was raised in the recent APPG report, stating that “[i]t was noted that the UK influence in health more generally ‘covers the two extremes’ of high-income countries through commercial partnerships and low-income countries in sub-Saharan Africa and South Asia through DFID, but this leaves a large number of countries where the UK has no influence”.

Conversely, some respondents noted the need to have some focus, given that UK capacity to respond to requests for technical cooperation is limited.

Another factor that was raised when considering the geographical remit was the consideration of broader UK diplomatic priorities, with the relationships formed being a tool of ‘soft power’. However, others noted that considering a focus based on UK priorities could then result in a supply-driven rather than a demand-driven model.

In short, there was no clear prevailing view amongst those who were interviewed, or involved in informal discussions about the priority geographical remit of such work.

Activities

As stated above, a general principle described was that this is about sharing technical knowledge with respect to particular aspect of a health system, rather than advocating wholesale adoption of the NHS system. The UK has a UHC system, and the values of UHC are understood by those working in the UK system, which was considered an overall strength. The need for a coherent, strategic vision for the activities and purpose to guide collaboration for health systems strengthening was raised. There is ongoing work on this by the NHS International Group to define a core UK offer, and DFID is currently developing a health systems strengthening framework. The Health is Global strategy provides an overarching framework, although with a wider remit than health systems strengthening. In addition, bilateral agreements are another way by which activities in partnership with particular countries are defined.

Aspects of the UK health system most commonly described as strengths were: education and training; priority setting including standards, guidelines, and health technology assessment; professionalism and revalidation; regulation; governance and accountability; information systems; primary care; public health and global health security.
In terms of specific activities that technical collaboration would involve, suggestions were: being a broker, catalysing South-South partnerships, joining a wider network for UHC and other health systems strengthening movements, working directly with multilateral agencies to provide technical advice, facilitating study tours, using domestic and in-country secondments, informal use of UK expertise by development organisations, virtual learning, curriculum development, and publishing reflections on the UK health service for an international audience/casebook.

In terms of the level at which collaborations would take place, the prevailing view was that this needed to be at all levels – including political engagement, direct work with policy makers, and technical/operational knowledge sharing.

Collaborations were also noted as a way of potentially improving the effectiveness of traditional ODA spending, as UK health institutions could also partner with multilaterals such as the GAVI, the Vaccine Alliance and the Global Fund to Fight Aid, Tuberculosis and Malaria (GFATM) on areas such as priority-setting of interventions to be funded.

The Health Policy Support Project (HPSP, China) (27-29)

DFID funded a £6 million programme, the HPSP to provide support for health systems strengthening, run with the World Health Organization (WHO) between 2005 and 2009. During the health sector reform in China, DFID and the WHO worked with policymakers in the Ministry of Health to support the development of pro-poor policies. The project provided a forum for ‘pro-poor stakeholder dialogue’

This was highlighted as an example of the type of technical activity that UK institutions could engage in. It could have a relatively large impact through facilitating pro-poor policy-making, through relatively small in financial terms. The Government of China injected $124 billion from taxes into the domestic health system. (28) The ‘additionality’ in such a situation is through sharing technical know-how rather than any additional financial aid. The suggestion was that the learning from this programme could also be used as an opportunity for further South-South learning, from the experience of China.

Funding

Two broad approaches for partnerships and technical cooperation generally described were ‘commercial’ and ‘philanthropic’. There were suggestions for a sliding scale, considering the country in question, to assess whether it was appropriate to have a purely philanthropic approach, a co-financing or cost-recovery approach, and, in the case of the high income countries a for-profit approach. Given the scope of this particular work relates to LMICs, the last approach is least relevant. The funding required for such systems-level technical
cooperation was thought to be relatively small/low-level. A not-for-profit cost recovery, in contrast to co-financing, could suggest the UK is providing a service rather than being a collaborator or partner for mutual learning. Depending on the nature of the request this could be construed positively or negatively, and goes back to the need to define a clear vision and purpose for the collaboration, including the degree to which it is also about learning for the UK. An additional issue is the feasibility of some funding mechanisms, depending on the organisations involved, as payment from one government to another is complex.

Characteristics that were desired for any funding modality were that it is: flexible, longer term, optimises use of a broad range of funding sources and grants, has sustained political will behind it, and, some suggested, provides funding beyond voluntary activity, to include staff engaged in a substantive way. There was a suggestion to build in potential long-term nature of partnerships into value for money considerations - longer-term partnerships beyond the funding cycle would not generally be developed from traditional technical assistance from consultancies.

Use of Official Development Assistance

If Official Development Assistance (ODA) was used to fund this work, there were some points that were raised. One point as discussed above is the extent to which such work would focus on bilateral DFID priority countries. Respondents highlighted that many countries that are considering UHC will be middle-income countries, and highlighted the ‘geographical gap’ that is also outlined on the APPG Global Health report, with most work occurring at the ‘two extremes’. (16) In addition, the majority of the world’s poor now live in middle-income countries. Many of these middle income countries are still on the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) recipient list (30), but are not the lowest-income or fragile and conflict-affected states that are the bilateral ODA priority for the UK. Some respondents suggested that funding to resolve this would potentially require methods such as not-for-profit cost recovery, or co-financing, with the partner country.

There was concern around tied aid and the extent to which prioritising funding to UK institutions for technical collaborations for health system strengthening would contravene the International Development Act 2002. This was raised with two aspects in particular: use of ODA to develop UK domestic capacity to respond to demand from LMICS; and any link with commercial work, or direct motive to improve UK commercial prospects through this work. Commercial diplomacy is an explicit part of the UK foreign policy agenda but DFID cannot use staff time or financial resources to promote UK commercial interests (but can support spin-off commercial benefits to the UK resulting from assistance, provided that they are not its
The importance of a clear governance structure delineating ‘commercial’ and ‘philanthropic’ work was highlighted by a number of people.

Conversely, this was, by some, suggested to be a model that is responsive to the changing nature of development work, in all but the poorest countries, as a form of ‘beyond aid’ partnerships. The IDC ‘beyond aid’ inquiry outlined the growing importance of development assistance beyond aid, including in the area of health. The concern around tied aid was also discussed, stating that “[w]e support the UK’s principled stance against tied aid, but this should not stand in the way of building links between middle income countries and UK institutions. We recommend that the UK be confident about its decision to continue its ‘beyond aid’ engagement in middle-income countries...”. Such work can also facilitate transition from financial aid, and the process of ‘graduation’ from aid.

Channelling demand

The barrier to channelling demand was considered to be the lack of a focal point in the UK to which demand could be channelled – as with coordination this was more fully discussed in relation to suggested approaches for systems-level partnerships in future. Most commonly, people suggested using in-country UK presence through DFID or the FCO to receive and facilitate articulation of the demand. Demand could come via NGO networks. Others mentioned that demand was channelled directly to their organisation, and felt this worked well and were reticent to have a further layer of bureaucracy that could end up acting as a barrier.

Electronic databases, were considered by most (but not all) who raised the issue to be too remote, and that channelling demand required direct person to person communication.

Other initiatives that were raised that had been developed include the Global Health Exchange, a recently launched initiative by Health Education North West. The vision of this initiative is “to provide a system, processes and platform that will enable the exchange of personnel and knowledge in the quest for improved healthcare, both in low and middle income countries (LMIC) and in the UK”. Other platforms highlighted include SPHINX by the Faculty of Public Health, and MedcineAfrica.

Coordination

As noted above, fragmentation was identified as an issue by most respondents. Health is Global was considered an important overarching strategic framework, however there is limited funding available to implement it and it finishes in 2015. It is also not specific to health systems strengthening.
In terms of enhancing coordination, this was principally considered with respect to suggested approaches for systems-level partnerships in future – which will be expanded further in the next section. It was noted that improved coordination would also facilitate better sharing of lesson learning for the UK from collaborations.

Another aspect of coordination noted as a challenge was coordination with other groups and avoiding placing additional burden on the partner country – which to some extent broadened the appeal of participating in networks. This is a longstanding challenge in development work more broadly and people cited DFID as the agency that would have the most experience facilitating solutions for this.

The Wales International Health Coordinating Centre (20, 36)

Public Health Wales hosts an International Health Coordination Centre that aims to bring together international health activity across Wales, mainly for Welsh health institutions but also linking to other key stakeholders such as Welsh Government and third sector organisations. The framework ‘Health within and beyond Welsh borders’ (2012) provided a commitment to working towards global health priorities.

The centre has developed a ‘Charter for International Health Partnerships in Wales’, with a view to ensuring that NHS organisations are following the same principles and standards of international work. It provides a ‘go to’ focal point for those in Wales who are setting up or already involved in partnerships. They are also committed to building capacity across the NHS and linking to the sustainable development agenda and health in Wales and globally. Next plans include exploring the development of a ‘global citizenship’ course for NHS staff and a new 3 year strategy. The centre has two dedicated staff members, with one additional staff member with some allocated time. More information: http://www.internationalhealth.wales.nhs.uk/charter

Prioritisation

Linked to the above themes around funding, geographical remit and coordination was the issue of prioritisation, particularly if ‘demand’ outstrips ‘supply’. Some highlighted that this was also intertwined with the development of a core UK offer – the extent to which demand could be met can be assessed on the extent to which the demand falls within the core UK offer and remit of work and the availability of funding to undertake collaboration. Beyond that, each request would need to be assessed case by case. A few respondents suggested the development of a theory of change for UK health institution collaborations as the systems-level for health systems strengthening, to better understand desired impact, underlying assumptions and therefore how to prioritise requests.
There was concern raised, as discussed previously, around the question of need versus demand, and emulating the ‘inverse care law’. The concern was that countries that request technical collaboration or partnerships may not have the greatest need, as defined by health outcomes or the state of the health system. Research on influencing policy highlights the importance of domestic-drive for change.(37-40) As such, although a demand-driven approach may not be primarily based on need, it suggests political will and desire for collaboration. This in turn would impact on the likelihood of sustained, locally-led change.

International Decision Support Initiative: Mapping of priority-setting in health for 17 low and middle countries across Asia, Latin America and Africa (41)

The Office of Health Economics (OHE) and NICE International developed a shortlist of countries for practical support for priority setting from the international Decision Support Initiative (iDSI). iDSI is a mechanism to provide peer-to-peer practical support to countries for policy makers, for priority-setting for UHC. It involves partnership amongst a number of organisations, including UK-based organisations. Funding is from the Bill & Melinda Gates Foundation, DFID, and the Rockefeller Foundation. A theory of change has been developed for the iDSI.

A longlist of 17 LMICs across 3 regions that could benefit from iDSI support was purposively developed. Following assessment of priority setting readiness, using qualitative and quantitative indicators, a shortlist of four countries was developed. The process considered the ‘supply-side’ and feasibility, the ‘demand-side’ i.e. wants and political will, and the level of need.

This provided a mechanism to prioritise support to particular countries, and outlines the criteria that were considered to be relevant when making this decision. The conceptual framework that informed the criteria was developed following stakeholder consultation.

Measurement

A commonly raised issue was measurement of results for technical collaboration and partnership working. A number of respondents suggested that reliance on quantification of impact distorted activity. This is compounded by the short time-frame of many funding cycles, and the nature of the work, as activity is focused on relationship building and sharing knowledge at a policy or institutional level, rather than easily quantifiable outputs. This is an issue that has been raised more generally, including in the Independent Commission for Aid Impact (iCAI) review on DFID’s approach to delivering impact.(42) While highlighting the influence of the results based agenda as a driver for accountability, the review also raised concern that it prioritised short-term economy and efficiency over long-term sustainable impact.
However, many also highlighted the importance of some mechanism of accountability for activity. Reconciling these issues requires the use of measures that allow flexibility, including and flexible logframes, and qualitative indicators to capture the nuance and complexity of collaborations,

The other aspect of measurement that was raised was the importance of documenting lesson learning for future not just ‘success’.

**Monitoring and Evaluation of the NICE International Health Partnerships Scheme (43, 44)**

Itad has worked with NICE International on monitoring and evaluation (M&E) of HPS projects in India and China. This follows from work to develop a Theory of Change for NICE International, and the development of linked indicators for pilot. There were six indicators, including quantitative and qualitative measures that were agreed.

The report of NICE International’s engagement in India and China presents findings in relation to each of the indicators. In order to collect data for the indicators the M&E team undertook key informant interviews with a range of stakeholders.

These openly accessible reports provide examples of novel indicators use to examine partnership work. The use of qualitative indicators, alongside quantitative data captured more nuanced information that would not be available through use of quantitative data alone. The report also provides a critique of the indicators that were piloted – their utility and how they could be refined.

4. **What are the risks of such partnerships and collaborations?**

All programmes and activities carry some risks, many of which are common to development or philanthropic work. Those outlined here are those considered to be more specific to this particular work.

**Doing harm**

There was concern around the experience of those working in domestic institutions with respect to their understanding of the development context and the risks around a focus tailored to domestic staff interests rather than being development oriented. The associated risk raised was of undermining local systems, and inadvertently diverting in country activity and limited human resource to activities associated with partnership building. There was also concern around the potential to cause diplomatic issues if not sensitive to the in country political economy. On the other hand, there was recognition that those currently working in
domestic institutions may have international experience. A joint approach with traditional development actors could mitigate against such risks, combining development and technical health systems expertise.

A further risk outlined was the risk of ‘pushing’ a UK model where it may not be appropriate. This also relates to discussion of ‘isomorphic mimicry’. Collaborations may encourage the development of institutions along a UK blueprint, but this would not achieve the aim of sustained, context-appropriate health systems strengthening. The importance of locally-led and owned processes, with flexible, iterative approaches that recognise complexity and avoid one-size-fits-all solutions is increasingly recognised. A genuine demand-led partnerships approach with the values and principles described above would mitigate against this, in partnership with technical health institutions from other countries, as occurs with the iDSI.

Reputational

Given the challenges with coordination, a number of people raised the reputational risk to the UK of appearing fragmented. There was also concern that limited UK capacity to respond to demands could risk not delivering on agreed activity.

As mentioned above, others suggested a reputational risk to be appearing to be promoting UK commercial aims.

In addition, a small number of interviewees suggested that opportunities for learning domestically and in the partner country may not be aligned. One example given was sending trainees to work in health systems abroad, which may be of great value to the trainee, and learning to use on return for the UK health system, but possibly of less value to the partner country who may benefit more from investment in different activities. This risks being seen, in a different manner, to be pushing UK interests.

Financial

The lack of availability of sustained funding was cited as risking short-term projects that do not have time to develop relationships and build trust, and have meaningful collaboration.

A further financial risk highlighted related to the risk of poor governance of funding streams and revenues, without a clear firewall between commercial and philanthropic work.

Domestic
A number of domestic risks were highlighted – the NHS is currently stretched/’in crisis’ which could impact upon the ability to engage, and the reputation of the NHS internationally. Whilst the NHS is an overarching brand, there is diversity (and ongoing change) of NHS models in England and Devolved Administrations and a huge array of separate NHS and non-NHS organisations that make up the health service in the UK. The English health service in particular is fragmented which could lead to a challenge of fully engaging on a particular issue (e.g. regulation), as the number of organisations in England that deal with different parts of the issue may be many and fragmented.

In addition, a further issue that was raised was the risk around public perception of being seen to be using any resource on technical collaboration abroad. There was a prevailing sense that it would need to be clear that resources allocated to the NHS are not being used to fund these systems level partnerships.

5. What sorts of approaches could be considered to respond to demand?

Respondents were asked what mechanisms could be used by the UK to respond more systematically to demand in the future, considering the issues described above.

While some stated that this was a work in progress and that there was no desire for new structures to coordinate UK partnerships in health in LMICs, others felt that current coordination was not adequate. There are fora looking to improve coordination but at the moment they are not in a position to receive and channel demand, and are predominantly fora to discuss activity and share ideas.

Where approaches were described, they fell into the categories outlined below. The below approaches are described in relation to health systems strengthening specifically, rather than all global health partnerships.

- Consortia of international arms of selected national organisations primed and funded to respond to requests. The consortia could be composed of a mixture of UK health institutions and traditional development NGOs to harness expertise. There would need to be a very clearly defined aim, to guide the action of organisations that may traditionally have different areas of focus.

- Centre established with cross-cutting expertise, to provide direction and as a ‘secretariat’. A ‘one stop shop’ with a broad range of expertise was proposed in the Crisp report.(17) The balance of expertise would need to be guided by the nature of demand.

- Managed fund to enable continuous work over the duration of funding and criteria to steer towards a smaller number of policy/systems-level partnerships. One example of
such a funding model is the Newton Fund managed by the Department for Business, Innovation and Skills ((49) for further information). The fund operates a matched funding/effort model. The aim is for UK research institutions to collaborate with research institutions in pre-specified ODA eligible countries for capacity building, research collaboration and translation of research.

- Cycle profits from commercial work to philanthropic work. This could incorporate a social enterprise model, and was suggested as a way of sustaining funding. The governance of commercial and philanthropic work would need to be clear and transparent. Commercial and philanthropic approaches differ (50), and this approach would need to encompass skills for both.

- Prime one region via an Academic Health Science Network with global health expertise to respond as a hub. This was put forward as a way of accessing cross-cutting expertise over a number of areas. However, a number of national level institutions would not be included, although they have a clear mandate in many policy areas.

- Small ODA budgets could be established for flexible use by selected other national organisations for partnership for health systems strengthening with overall oversight from DFID. However, this would risk the ongoing fragmentation of the activity of various organisations, and does not clearly address the issue of coordination.

In order to further develop ideas, scenario testing of various potential approaches could be used as a tool to examine the above approaches from articulation of demand to development of a partnership. This could include a mix of low and middle income countries from different geographical regions to understand how requests for partnership and collaboration would be handled using the approaches outlined to further develop them. The scenario testing could also include an assessment of the balance of risks, to understand how various approaches could impact on the risks, and what would need to be in place to mitigate the risks.

A further consideration is the cost of the various approaches, and how they could be sustained. Intrinsic to this is a more specific understanding of the core UK offer for health systems strengthening and funding for this.

There may be learning from other sectors where technical collaboration has occurred with institutions in LMICs – those that were mentioned include tax reform, electoral reform and education.
Conclusions

Health systems strengthening and UHC are high on the global health agenda. Looking to the future, there is the opportunity to strengthen collaboration on health systems strengthening with LMICs, with the ultimate aim of improving health outcomes. The UK has a cost-effective universal health coverage system and a number of respondents highlighted the demand for collaboration. The APPG Global Health/LSHTM report highlighted the large-scale contribution the UK has made to health globally in a number of areas.(16) This has been achieved through the dedication, perseverance and commitment of a number of individuals and organisations.

There is the opportunity for the NHS and other UK health institutions to engage more systematically at the policy-level, and the development of a clear mechanism that at the least provides a secretariat function could help achieve this. The particular area most consistently raised that needed to be strengthened for UK technical partnerships and collaborations was coordination, to overcome fragmentation of activity amongst UK state sector health institutions.

Looking to the future, a clear vision, strategy and theory of change for technical collaboration for health systems strengthening in LMICs across UK state sector organisations would guide activity through defining the purpose, priorities and desired impact. Many individual organisations have developed strategies for global health more broadly, articulating a number of principles to guide the work (20-24), and there are frameworks for aspects of activity such as volunteering.(8, 9) An overarching strategy that is informed by empirical evidence on the nature of demand for collaboration could provide a clear purpose and enhance coordination, and draw together the various strands of work currently ongoing. The DFID framework on health systems strengthening that is currently being developed may address this.

The approaches that were suggested to manage and respond to demand for technical collaboration will require further development and assessment, including a clear assessment of the associated risks. Irrespective of the approach, the UK would need to be confident that it is best placed to respond to any particular demand and has the capacity to deliver. This requires a clear recognition of the UK state sector’s strengths and weaknesses. An approach where the UK works in partnership as part of a network with technical health institutions from other countries could help to address this, and would also help facilitate South-South collaboration - the iDSI is an example of this.

Broader discussion on influencing change and technical collaborations chime with the prevailing perspectives among interviewees. There is a growing movement Doing Development Differently (DDD) which advocates for flexible, locally-grounded approaches that recognise complexity and aim to find solutions.(46-48) This also moves away from the idea of trying to work according to a blueprint – and respondents were clear this was not
about pushing the NHS model. The DDD approach may be useful to consider for technical cooperation approaches by the UK with respect to health systems strengthening. Many respondents felt that the nature of partnership work, and the difficulty generating linear quantifiable outputs hindered the development of sustained, high-level partnerships that recognised complexity. Ongoing work to develop novel indicators to monitor and evaluate collaborations for health systems strengthening should also continue to be supported.

Moving this agenda forwards, which is in line with the current government’s manifesto commitments, will require concerted political commitment and action at the highest level, across government, in order to:

- mainstream the idea of partnership working and technical collaboration with low and middle income countries in UK health system institutions, beyond clinical or provider level volunteer models
- secure the required resources for substantive and sustained engagement
- develop a more coherent approach to middle income countries, as part of the ‘beyond-aid’ agenda. Middle income countries are a heterogeneous group that will include many of the countries looking to develop and improve provision of universal health coverage. This includes consideration and further clarity on the use of ODA to support this activity where it has genuine development objectives, as many middle income countries are not DFID priority countries for bilateral aid, but are on the OECD DAC recipient list.(30)

Such collaboration can complement the drive for the UK system to engage in commercially-driven business overseas. It will enable to development of relationships and knowledge sharing in contexts where commercial means are not appropriate, and indeed may facilitate development of a commercial inroads further down the line. An over-reliance on commercial enterprise as the predominant way in which the UK health system works internationally risks short-term projects that do not afford the benefit of a sustained relationship for mutual learning. The value of such longer-term partnerships and collaborations should also be incorporated into Value for Money assessments.

Whilst there are challenges, what is clear is that there are individuals in the UK health system with a lot of enthusiasm, commitment, thinking and will to move this forwards.
References

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