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THE TRANSITION FROM AID

What does it mean for the UK's engagement with health systems in middle-income countries?

THET Discussion Papers

The 'Transition from Aid' is part of THET's Discussion Paper series, which address challenges within an ever-changing development landscape. They are designed to stimulate discussion within our organisation, the broader development community, and the wider policy environment.

Each is written with the assistance of external expertise. We welcome comments and further discussion, please contact **Graeme Chisholm, Policy Manager**: graeme@thet.org.

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The transition from aid

What does it mean for the UK's engagement with health systems in middle-income countries?

The transition from lower- to middle-income status is complex and raises significant questions for the role of aid in the years ahead. From a health perspective, the challenge is how to sustain investment in healthcare and how to maintain and strengthen access to equitable healthcare in these countries as they strive to achieve Universal Health Coverage.

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Executive summary

The UK's commitment to Official Development Assistance (ODA) or 'aid' has become the focus of significant political debate in recent years. Following legislation in 2015, the UK numbers among a small handful of nations globally – and the only one in the G7 – to have a legally-binding obligation to spend 0.7% of Gross National Income (GNI) per year on aid. This has seen UK aid spending double over the past decade to reach almost £14bn in 2017-18.

At the same time, pressures on domestic spending following the 2008 crisis and the uncertainty created by the vote to leave the European Union in 2016 have prompted many commentators to question aid priorities. Increasingly, the 'mood music' in Government stipulates that aid should not only alleviate extreme poverty in the poorest countries, but also create commercial opportunities that benefit the UK, as well as recipient nations themselves.ⁱ

In this report, we make the case that, to meet these new aid priorities, it is important to recognise the role of UK engagement with middle-income countries (MICs). This diverse group of 109 countries, divided into 'lower' and 'upper' middle-income by the World Bank, have a GNI per capita ranging from \$1,006 to \$12,235.ⁱⁱ This definition includes some of the world's fastest growing economies, such as China and India, but also many other countries, especially in Sub-Saharan Africa, where average incomes are barely above subsistence level.

In particular, we argue that the UK's healthcare sector should be seen as a vital component of this revised approach to aid as the economies of MICs continue to grow. The NHS is widely regarded as the UK's most treasured institution, and yet its potential as a driver of development and commercial exchange between the UK and other countries is under developed. As a leading coordinator of healthcare exchanges between the UK and other countries,

THET believes strongly that these partnerships are critical for tackling poverty and inequality worldwide. In a world where innovation is increasingly originating in the Global South, we believe the potential for mutual benefits to flow both ways is enormous.

In the context of Brexit, and the UK's desire to remain an outward-looking country open to partnerships and new ideas, the principles underpinning the NHS also make it an attractive partner for many MICs as they seek to extend equitable Universal Health Coverage (UHC) for their populations. As such, we believe the NHS should be viewed as a great potential 'export' for the UK commercial community (UK plc), in much the same way as our strengths in Higher Education. Government has already recognised this potential in the establishment of Healthcare UK, a joint initiative of the Department for International Trade, the Department of Health and NHS England.

This paper is primarily intended to stimulate discussion on some of the issues we raise. But we also make a number of specific recommendations which we believe have the power to maximise soft power gains, establish the UK as a leader in global workforce development and increase the commercial success of the NHS and wider UK healthcare ecosystem internationally:

1. Promote Universal Health Coverage.

By ensuring the NHS is able to engage effectively internationally, the UK can position the NHS and its values of equity and fairness as the healthcare model of choice for MICs.

2. Mobilise UK health workers.

The UK Government and devolved administrations should continue to invest in schemes that mobilise UK health workers to work overseas recognising the value they hold as a tool for strengthening high quality, equitable health systems in low-and middle-income countries whilst also advancing the UK's national interest.

3. Be clear on donor transition.

The UK Government should publish a framework to guide the transition process from the Department for International Development (DFID) programmes and investments to new relationships which may be led by other Government departments.

4. Lead on global health workforce development.

New centres should be established in each of the UK nations to promote, coordinate and develop the role of the NHS as a leader on global workforce development, in recognition of the estimated shortfall of 18 million in qualified healthcare workers globally by 2030.

5. Lead on global learning exchange.

The NHS should incorporate explicit objectives to observe and learn from middle-income country practice into health partnership mission statements. We recommend establishing formal forums to disseminate such practice within NHS organisations.

6. Be transparent and strike the right balance where aid and commercial interest intersect.

Further assist the establishment of strong, sustainable, and equitable healthcare whilst highlighting the mutual benefit this brings for both MICs and the UK.

7. Realise the commercial potential of the NHS.

Over the coming years there are likely to be increased opportunities for the UK to provide its advanced health sector skills and commodities on a for-profit or part-subsidised basis to a growing number of MICs. Healthcare UK should engage the UK public sector in discussions about international work through a series of roundtables throughout the country.

Introduction

World-class health services are being developed in countries across Africa and Asia, offering new opportunities for bidirectional learning, the recruitment of health workers, and commercial exchanges with the UK.

As economies develop and more and more countries reach middle-income status, the responsibility for addressing problems of poverty and inequality increasingly rests with the governments of these countries. How could it be otherwise? They are making choices about the use of national resources which impact on their citizens' ability to access healthcare.

Inequality persists with grave consequences for the social and economic development of these countries. Taken together, 960 million people - 'the new bottom billion'ⁱⁱⁱⁱ - live in abject poverty in MICs. Poverty, an inability to access healthcare services, and a shortage of health workers sit cheek by jowl with great affluence and first-class healthcare. Never has the world been more unequal nor inequality expressed so acutely within - as well as between - countries. The 'job' of development, articulated so ambitiously with the adoption of the Sustainable Development Goals (SDGs) is far from complete.

What does this mean for the use of UK ODA, or put more simply 'aid,' the work of international development charities such as THET and our partners across the UK health community?

Should we disengage from MICs? There would be support for this position, not only in sections of the UK media but also from within the countries themselves. Or do we continue to engage? And what form should our offer take? Is it aid, or is it commerce? Or is it the meeting point between the two? What does it mean to operate at the nexus of commercial opportunity and traditional aid?

In this discussion paper, we explore what it means to engage in a range of MICs, from lower to upper, and how the nature of aid is changing in response to this rapidly changing world.

The World Bank classification of countries explained

Lower middle-income economies are those with a gross national income (GNI) per capita of as little as \$1,006 or less than \$3 a day and upper middle-income economies are those countries with a GNI per capita of as much as \$12,235 or more than \$33 a day. So there exists a large difference in wealth between the poorest lower middle-income and the richest upper-middle income country.

1. Context

1.1 A rapidly changing world

The world is changing fast and so too is the entire aid landscape. We are seeing a rapid progression of countries moving from low-income to middle income status.

As economies in these countries develop, the responsibility for addressing problems of poverty and inequality increasingly rests with the governments of those countries.

China, for example, in terms of GDP per capita, is as wealthy a country today as the UK was in 1948 when the welfare state was created. India's economy is the fastest growing large economy in the world, with a total GDP expected to move ahead of the UK by 2022.^{iv} And yet India does not have a welfare state, with only 17% of its population insured for healthcare needs.

These countries are making choices about the use of national resources and these choices impact on their citizens' ability to access healthcare.

Should the UK disengage with rapidly developing economies such as India and China? There would be support for this position, not only from large sections of the UK's population as reflected in the UK media but in countries like India as well.^v

However, extreme inequalities still exist in India and China as well as other MICs, which the World Bank categorisation does not adequately capture.¹ The face of global poverty is changing, a "new bottom billion" of 960 million poor people now live in MICs. This means that 72% of the world's poor are in MICs – a dramatic change from 20 years ago when 93% of poor people lived in low-income countries.

Although UK aid has fallen to negligible amounts in some of the wealthier MICs such as India or South Africa, many countries at the lower end of the middle-income country spectrum such as Bangladesh or Zambia are almost as much in need of on-going support as they were when they were classified as low-income. And many MICs are still vulnerable to internal and external shocks, or are recovering, or suffering, from conflicts.

Looking at the UK, our health system can be viewed as already international in nature. 11% of NHS employees and 26% of doctors^{vi} are not from the UK and many parts of the UK health system, for example, Public Health England and Health Education England, are all establishing international arms to their operations.

We are living in a world where health challenges are spreading beyond national borders and require global efforts to both respond to health emergencies and prevent future health crises. The West African Ebola outbreak, the spread of the Zika virus, and the rise in anti-microbial resistance are all examples of recent and current challenges that have precipitated a global response. And there is a growing appreciation of what poverty and failing health systems overseas means for the UK. Think of Ebola.

"Building a healthier world helps to ensure a healthier Britain"^{vii}, a recent paper from the Conservative Party observed. "The UK's response to the Ebola crisis in 2014 and 2015 was a great example of this, putting our world class NHS workers and armed forces personnel to the task of fighting a disease that was taking thousands of lives and setting development back years"^{viii} but also addressing a threat that had no regard for geographical borders.

1. It can be argued that 'Least Developed Country' classification is a preferable measure as it incorporates both national income and social development indices and also degree of exposure and vulnerability to external shocks.

1.2 Changing attitudes towards aid

The UK continues to make outstanding contributions to aid. It is in fact, the sixth most generous country in the world, if you take its spending as a proportion of GNI. For every hundred pounds that's made in the UK, seventy pence goes towards foreign aid.^{ix} In 2015 this target was made law. However, beyond the impressive figures are some seismic changes in attitudes to aid amongst politicians and UK citizens.

The majority of people in the UK do not view global poverty as an urgent problem and want lower spending on aid.^x Many believe aid ends up in the pockets of corrupt dictators and politicians.^{xii} To this end aid is increasingly becoming a target for newspapers and commentators to advocate for budget cuts especially when an estimated 1.1 million Britons use food banks.^{xii}

This is sometimes described as 'aid fatigue'^{xiii}, and it is expressed in recipient countries as well as donor countries.

*"There is something deeply
condescending about receiving aid
from a foreign country, especially one
that has ruled you for 200 years.
Self-respecting nationalists should
welcome the UK's decision to
stop aid to India in 2015."
Meghna Roy^{xiv}*

2. Discussion

The response to this changing context is challenging and diverse.

2.1 Our national interest

Strong voices continue to make the case for aid as a principled and moral position for the UK to take. As we have seen, the UK has met the global commitment to allocate 0.7% of GNI to ODA^{xv} It has been argued that this commitment is not only morally right but also in our national interest.^{xvi}

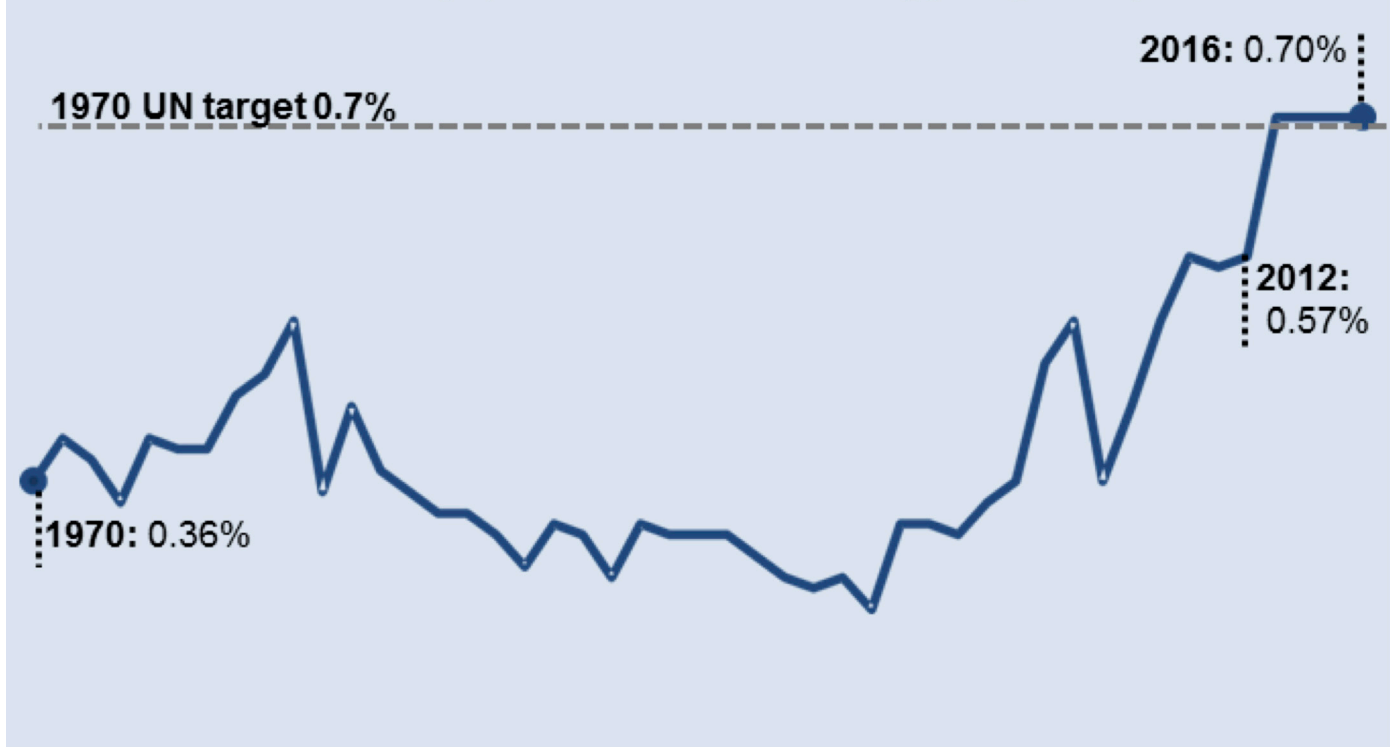
A central theme of the UK Government's latest aid strategy^{xvii} is therefore ensuring that aid delivers benefits that are in the interest of the UK. This theme was reiterated by the former Secretary of State for International Development The Rt Hon Priti Patel MP most recently at this year's British Overseas NGOs for Development (BOND) annual conference in March 2017:

*"UK aid along with our world-class
defence and diplomacy acts not only
in the interests of the world's poorest,
but in our own national interest"*

The 0.7% target allows the UK to claim an international leadership role.^{xviii} In a speech to the UN General Assembly, the former British Prime Minister, David Cameron, said it was not only a moral obligation that better-off countries have to tackle poverty in a world where more than 1 billion people live on less than a dollar a day; he argued it was also in everyone's interest to build a more prosperous world, otherwise the problems of conflict, mass migration and uncontrollable climate change "will come and visit us at home".^{xix}

Earlier this year, the current British Prime Minister Theresa May described the 0.7% target as a "critical pillar" of the country's foreign policy when put under pressure to confirm that she would maintain the commitment prior to the recent snap election.^{xx}

UK's ODA:GNI ratio (%) Current methodology in given year



Source: *Statistics on International Development 2017, DFID.*

2.2 Our mutual benefit

This has given rise to an appreciation that aid is given in ways which bring mutual benefit.

Recent decades have seen the gradual erosion of the concept of 'development aid', whereby a wealthy donor country gives aid (with or without conditions) to a poorer, low-income country. This is expressed as strongly by recipient countries as it is by donors. Not only is there now a growing expectation that all countries in the world, whether rich or poor, must play their part in lifting the poorest people out of poverty, but there is an increased emphasis on mutual benefit.

Alongside a focus on failing states and humanitarian interventions, building resilience and responding to crises, both of which bring a strong focus on health and global health security², there is a renewed emphasis on promoting global prosperity. The UK Government believes that this will directly

contribute to the reduction of poverty and also strengthen UK trade and investment opportunities around the world. The benefits to the UK from contributing to health globally are in fact considerable.

This can be seen in the arena of health. The UK's Medical Royal Colleges, for example, will market the benefits of membership and examinations to health professionals in Myanmar whilst simultaneously seeking aid funding to build skills and capacity with their peers.

Organisations such as THET are increasingly collaborating with the private sector, building capacity in non-communicable diseases (NCDs) in Ethiopia, for example, to bring healthcare to the rural poor whilst simultaneously assisting our partners in their longer-term ambition to achieve market share in these countries.

2. The £1.5 billion Global Challenges Research Fund is enabling the UK to harness the country's expertise and leading research base to strengthen resilience and response to global health crises, while the £1 billion Ross Fund is enabling the development and testing of vital vaccines, drugs, diagnostics, treatments and other technologies to help combat the world's most serious diseases in low- as well as middle-income countries.

2.3 Striking the right balance

But accompanying this deepening understanding is a growing appreciation that benefit to both parties cannot be taken for granted.

And civil society in the UK has been vocal in its attacks against aid supporting UK interests at the cost of poverty reduction in low and middle-income countries:

“By underlining that poverty reduction must be the primary purpose of aid, the International Development Committee have shown that the new UK aid strategy puts us in dangerous water, and risks diluting the UK’s position as a leader in international development.”

Saira O’Mallie, ONE campaign^{xxi}

“Focus on aligning aid spending with ‘the national interest’, national security priorities and the interests of UK companies could result in UK aid (a scarce and unique resource) being directed to different priorities less focused on meeting the needs of the most vulnerable people.”

Development Initiatives^{xxii}

THET also sees risk in an over-emphasis on aid supporting UK interests. But THET also believes that countries, be they high, middle or low-income, are all in some sense ‘developing’ and that we all face constraints and challenges. THET therefore supports the maximising of learning opportunities between health systems. We are not doing enough of this, nor doing it well enough.

Transparency is important in this area. Seeking training and learning overseas in order to benefit the NHS, for example, should not be disguised as ‘overseas development’ bringing benefit to those overseas countries.

THET therefore argues that we should be clear about the mutual benefits which are achieved but that we must also ensure that we strike the right balance between low- and middle-income country and UK interests. Key to this balance includes ensuring careful programme design that respects aid

effectiveness principles along with policy interventions that secure mutual benefits, as we illustrated in *In Our Mutual Interest*.^{xxiii}

The benefits this brings to MICs are many and varied. These include understanding better how to tackle global epidemics and NCDs through improved research; supporting countries to achieve UHC through sharing the UK’s expertise as well as advocating, and helping civil society to advocate, for everyone’s right to health.

To take one example, that of the Health Partnership Scheme which has been at the forefront of establishing this evidence base. In the last six years the UK has trained over 84,000 nurses, doctors, midwives, community health workers and other medical workers. This has made a direct contribution to supporting a number of MICs such as Cambodia, Kenya or Zambia, on their journey towards UHC.

So the question is not whether the UK has a contribution to make but rather how we maximise our contribution whilst also ensuring a more equitable world.

The transition from low to middle-income status is a complex process for many countries and will involve both philanthropic and commercial interventions along with well-considered exit strategies from donors such as the UK Government.

If the UK is going to address poverty and marginalisation and maximise its contribution to the achievement of globally agreed ambitions, such as UHC, then having a more thoughtful approach than at present to the type of global health interventions and support we provide to the increasing number of MICs is critically important.

3. The role of the UK

It has been persuasively argued that by combining the strengths of its academic, Government, commercial and not-for-profit sectors the UK can continue to be recognised as a global leader in health.^{xxiv}

Supporting the achievement of SDG3, 'the health goal', presents opportunities for the UK to demonstrate its leadership and expertise in health systems strengthening, through both the leadership of DFID in international development and the experience, expertise and lessons that can be drawn out of the NHS for an era in which UHC is the guiding vision.

We have seen that our health system in the UK is already internationally engaged. But given that there exist cross-sectoral opportunities for the UK to contribute to global health, the question is how the UK can play a greater role in health, research and education, public health, healthcare, life sciences, and policy-making globally, whilst also benefit for the UK.

The UK has a choice: to actively engage or to simply react to circumstances.

THET believes that we should choose active engagement because:

- a. We believe in the NHS as a world leading system for delivering UHC.
- b. It is good for the UK in the time of Brexit.
- c. The world faces a crisis in skilled health workers and it is time to find common solutions to common/global challenges and the NHS can lead on this.
- d. The UK can gain, as well as give, by tackling the global crisis in skilled health workers together.
- e. It positions the UK for commercial opportunities.

a. We believe in the NHS as a world leading system for delivering UHC.

In the UK, our NHS is continually in the news for all the wrong reasons.^{xxv} Indeed, with the NHS's ability to deliver on its founding principles under greater pressure than ever, the question continually asked is whether it can survive at all.^{xxvi}

But in the field of global health, the NHS, despite its many challenges, is universally recognised as a highly effective model for ensuring everyone can access healthcare free at the point of delivery without the fear of incurring catastrophic health expenses.^{xxvii}

So as international discussions on the financial reforms required to deliver UHC rapidly progress, the NHS as a model of care has much to offer.

THET believes that the promotion of this in the global health arena is critical because, as more countries in the world move towards middle-income status, it becomes increasingly important to ensure that the needs of the poorest within these countries continue to be met.

The NHS and its founding principles serve as a highly-valued model for ensuring the poor don't get left behind.

b. It is good for the UK in the time of Brexit.

While it is difficult to predict what Brexit means for the UK's engagement with MICs, there is an increasing likelihood that more aid spending will be shifted away from DFID; that more aid may be used for business investment, and that development may in fact be pushed down the political agenda.^{xxviii} It will therefore be important for donors such as the UK Government to set-out clear frameworks to help guide middle-income transition processes in order to support coordination between, for example, several Government departments as well as with other donors.^{xxix}

Estimates of health worker need

It is also likely to become more challenging to recruit and retain health workers in the UK health system if freedom of movement is restricted as a consequence of Brexit. For example, new registration of nurses from EU countries with the Nursing and Midwifery Council have dropped sharply since the referendum vote from over 1,000 per month in April 2016 to less than 50 per month by April 2017. Uncertainty also remains over how many of the 25,000 foreign-trained nurses from EU countries currently practicing in the UK will be allowed or will ever choose to remain.^{xxx}

And so with Brexit becoming an increasing reality, THET argues that committing to the 0.7% but offering clear guidance to MICs on donor transition and acting creatively on workforce development issues will help the UK maintain its position as a world leader and show that leaving the EU does not necessarily mean isolationism.

c. The world faces a critical shortage of skilled health workers and it is time to find common solutions to global challenges: the NHS can lead on this.

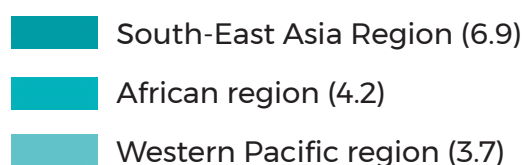
Globally there exists a shortage of skilled health workers. By 2030 the gap is expected to be 18 million.^{xxx} Demand outstrips supply as systemic underinvestment in training meets growing needs due to population growth in poor countries and aging populations in rich countries.^{xxxii}

There is a rapidly increasing focus on promoting health reforms across low as well as MICs with the aim of securing UHC. There is an urgent need to seize the opportunity presented by the increasing attention on achieving UHC. Currently, however, the political space for determining the shape of health reforms is dominated by agencies such as the World Bank.

The WHO Global Code of Practice on The International Recruitment of Health Personnel^{xxxiii} recommends that systems of international recruitment of healthcare workers should be designed in order to mitigate any negative effects in the country of origin. The Code can best be viewed less as a ban on recruitment and more as a set of



Needs-based shortages (in millions)*



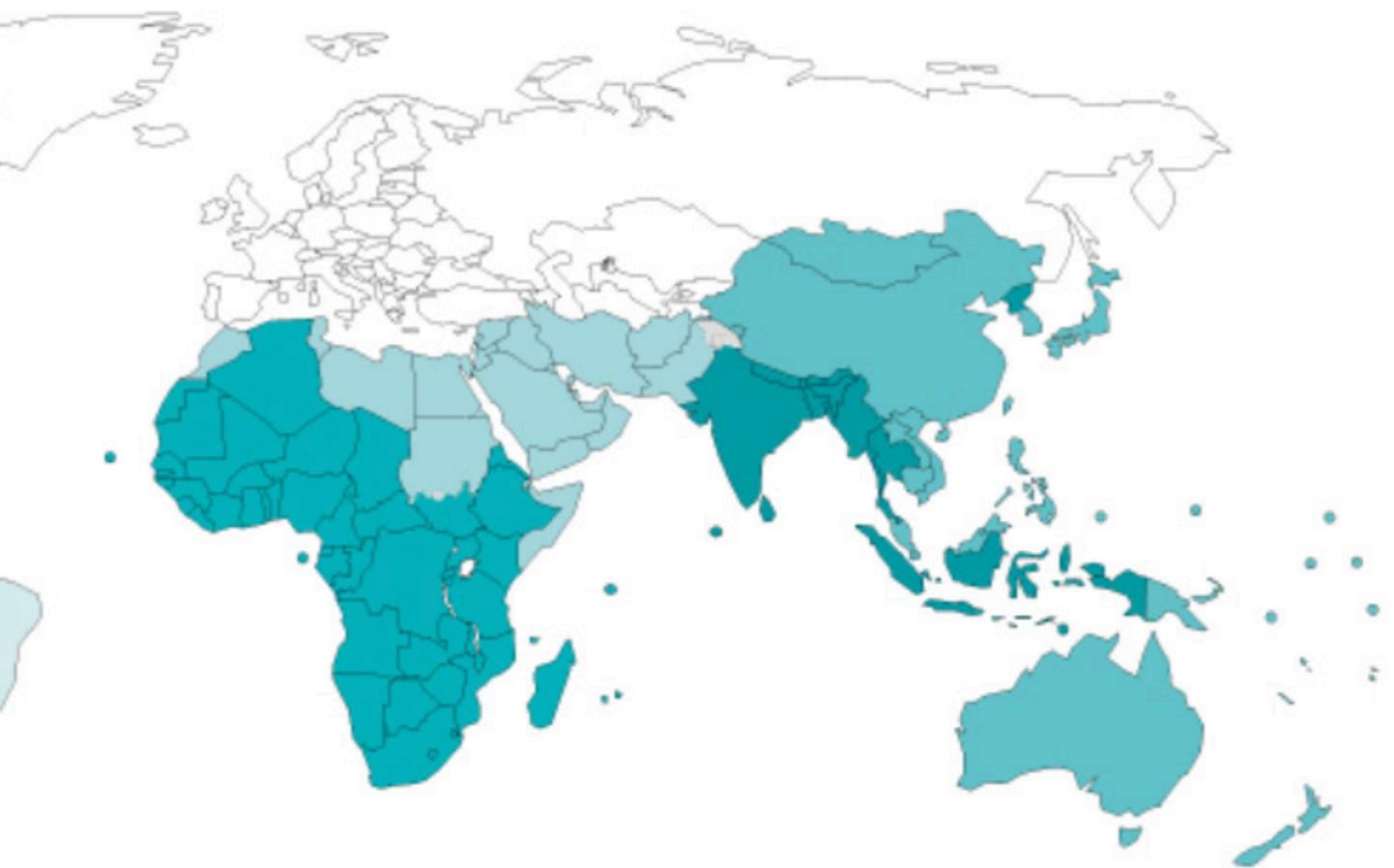
*Needs based shortage is estimated as the difference between need and supply.

The boundaries and names shown and the designations used in this map do not imply the legal status of any country, territory, city or area or its authorities, or the endorsement of THET for any such designations. ©WHO 2017. A Data Source: World Health Organization. Map production: Informa

recommendations for how recruitment should be conducted ethically.^{xxxiv}

THET believes that the UK can move from competition to collaboration in the recruitment and education of health workers, in ways that bring mutual benefit to the health systems of all countries and address the shared 18 million recruitment challenge.

Needs-based shortages, by WHO region, 2013



- Eastern Mediterranean Region (1,7)
- Region of the Americas (0.8)
- European Region (0.1)

ed and supply by country for those with current supply below the SDG threshold.

This map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the status or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be a firm agreement. All rights reserved.

Information Evidence and Research (IER) - World Health Organization

The NHS is a global leader in workforce education and training, recognised both in terms of the quality of the educational opportunities but also the low cost, in comparison to other developed countries, and so can lead the way on this development of the global workforce.

d. The UK will gain as well as give by tackling the global crisis in skilled health workers together.

As we illustrated in *In Our Mutual Interest*, over recent years there has been an important shift towards bidirectional learning, which suggests that the UK is increasingly gaining as much as it gives when engaging in global health, with evidence mounting on how individual learning is leading to



“If I was asked to talk to the Secretary of State for Health about this programme (*the Health Partnership Scheme, ndr*) I would say, ‘Take real notice of this!’ Because these skills we learn here can go such a long way back home.”

Dr Charlie Gardner, volunteer for the Improving Global Health & the Maddox-Jolie-Pitt Foundation partnership (Cambodia).

a more responsive, motivated and innovative UK health workforce. There is however still little evidence of innovation in practices or technology being introduced back into the UK that originate in MICs.

Engaging UK health workers in global health can improve the skills of the NHS workforce. But for the decade ahead, the NHS budget is likely to be under pressure. Over the same period, demand for NHS health care is expected to rise as people live longer, have more complex health problems, and more advanced treatments become available. So how can the learning of UK health workers engaging in global health be maximised in this challenging financial climate? And how can we combine this with learning for counterparts from MICs?

THET is supportive of those who are forging ahead at a UK health system level to find pragmatic ways of developing workforces in both settings. For example, Health Education England have been in discussions

with one of India’s largest healthcare providers to offer postgraduate training in the NHS to nurses from India for a limited period on an ‘earn, learn, return’ basis.

THET also supports the work being conducted to think through possible models of global learning. For example, Investing Aid in a Global Skills Partnership sets out a cost-benefit analysis of different training exchange models, and recommends that a combination of cheaper international training (in the UK as well as in a low- or middle-income country) along with labour mobility creates the largest net benefit and delivers good value for money for UK aid.

This approach to the development of the global workforce which encourages bidirectional learning could also encourage innovation where specific practices or technology originate in lower MICs.

e. It positions the UK for commercial opportunities.

Commercial opportunities will inevitably outpace aid as countries further develop towards middle and high-income status. Therefore pursuing a combination of aid and trade activities will address both ongoing health development needs in MICs and UK commercial interests. These activities take many forms some of which emphasise aid with trade a secondary consideration – reflecting to some degree the changing nature of aid, others place aid and trade on an equal footing, while others focus purely on the commercial. We give some examples below.

New forms of aid

The UK has clearly recognised the opportunities for building a continuum of ‘aid through to trade’ as countries progress from low- to middle-income status. The UK’s cross-government Prosperity Fund now forms a strategic proportion of the UK’s total aid budget. This fund aims to promote the economic reform and development needed for growth in partner countries through providing expertise and technical assistance in areas of UK strength such as infrastructure, energy, finance, education and healthcare. As well as providing aid to reduce poverty, the UK Government aims to improve the business climate and the competitiveness and operation of markets, creating greater opportunities for international business, including UK companies.

THET believes that the establishment of the Prosperity Fund offers an opportunity for partnerships between, for example, UK Government departments and arms-length bodies such as Public Health England and organisations such as Healthcare UK, to improve access to equitable and high quality healthcare in middle-income countries whilst generating future opportunities for UK healthcare suppliers.

Cross-sectoral partnerships

The boundaries between programmes delivered through aid and those delivered through other forms of finance are blurring.

Partnerships between international non-governmental organisations (INGOs) and corporates have a long track record. A partnership between GSK and Save the Children, for example, focuses on improving access to basic healthcare, through prevention and treatment, training and equipping health workers in the poorest communities, developing child-friendly medicines and working at local and global levels to call for stronger child health policies.

Another example of an INGO working in partnership with corporates is that of CARE International working with Barclays and GSK to develop a social enterprise model in Zambia to give more people access to affordable healthcare and support entrepreneurship.

“At Barclays, we recognise that the success of our business is linked to the growth of the societies in which we operate.”

By working through long-term partnerships, THET believes that the UK is well placed to broker international health partnerships between academia and the public sector to work with corporates on projects rooted in country need in the increasing number of MICs.

For example, pharmaceutical companies are unable to deliver inclusive business models for NCDs throughout sub-Saharan Africa. The rural populations of the subcontinent are situated too far away from health institutions to be able to benefit from access to treatment for the majority of long-term conditions. But cross-sectoral partnerships rooted in local need could deliver the healthcare these populations need.

Commercial relationships

The mutual benefits of developing commercial relationships in emerging markets overseas are increasingly important to the UK. And the transition of many countries from low- to middle-income status presents the UK with opportunities for advancing the interests of both parties.

THET believes that commercial income should be embraced where there are mutual benefits. There are advantages in some ‘honest commercial

transactions' compared to strictly 'charitable relationships'. We therefore welcome NHS and wider UK health system engagement in both commercial and aid opportunities.

Specific examples, particularly as countries move towards upper-middle-income status, include:

- The UK's Royal Medical Colleges' promoting membership; licensing of exams and overseas exam centres; and accreditation of training programmes, institutions, short courses and events and conferences.
- UK universities beginning to set up campuses overseas, extending the quality of UK higher education to students in those countries. For example, overseas campuses including the Newcastle Medical School campus in Malaysia and Glasgow Caledonian University and the Grameen Trust's Grameen Caledonian College of Nursing in Dhaka, Bangladesh.
- UK increasingly investing in life sciences companies, for example in India, therefore enabling local healthcare companies and institutions to acquire from and provide services and technology to the UK at the same time.

In addition, Healthcare UK is helping the UK's public and private sector providers of healthcare to do more business overseas in UK Government priority countries in Central and Eastern Europe, the Gulf, Latin America along with India and China. In these countries commercial opportunities for the UK's support to high quality healthcare are already being realised.

Healthcare UK secured contracts to the value of £3.7 billion with 67 partners during 2015/16. Work delivered as a result of these contracts has been mainly through the private sector and includes strengthening healthcare infrastructure and delivering clinical services. More specifically, this work has included building hospitals, providing training on different aspects of healthcare and supporting the development of IT systems for clinical care and management of information.

The scale of opportunity in some upper MICs such as China are enormous and continue to grow. For example, the rapid expansion of universal health insurance coverage for almost the entire population in China over recent years has been accompanied by rapid increases in Government healthcare expenditure.

4. Conclusion

In this discussion paper, THET has argued that the need for UK engagement in MICs remains pressing, as they transition to greater economic and social stability, poverty, an inability to access healthcare services and a shortage of health workers sit cheek by jowl with great affluence and first-class healthcare.

We are intimately connected with their fate, not just because we have a moral duty to engage in our global community, but because it is in our own interest: as the spread of disease and anti-microbial resistance reminds us; “Building a healthier world helps to ensure a healthier Britain”. We have seen however that MICs do, quite naturally, aspire to make the transition from dependency on aid and so it is incumbent on big donors such as the UK Government to set out clear guidance on what this transition may look like.

The NHS is already an internationally-engaged health service, with a very high percentage of its workforce recruited from overseas. But its workforce are also first-class ambassadors for the UK overseas, travelling in increasing numbers to train and educate workers overseas supported by, amongst other programmes, the Health Partnership Scheme.

The NHS is a model worth exporting. These partnerships can, and in our view should, take full advantage of the range of expertise that ‘UK plc’ has to offer. Where their expertise and ability is not contained in, or mobilisable from, the public sector these partners can play a key role in supporting health ministries and their work with the NHS to improve health and care systems. At the same time, the NHS is facing unprecedented challenges which mean that it must look outside itself to learn and innovate. Through its experience in managing the Health Partnership Scheme, THET has gathered evidence to show the value working overseas can bring to our NHS.

The mutual benefits of developing commercial relationships in emerging markets overseas are increasingly important to the UK. And the transition of many countries from low- to middle-income status presents the UK with opportunities for advancing the interests of all parties involved.

THET believes that commercial income should be embraced where there are mutual benefits. There are advantages in some ‘honest commercial transactions’ compared to strictly ‘charitable relationships’.

The recommendations outlined in the following section of this discussion paper represent a starting point on that journey, but they should not be viewed as an end goal in and of themselves.

5. Recommendations

We believe that the following recommendations can support soft power gains, establish the UK as a leader in global workforce development and increase the commercial success of the NHS and wider UK healthcare ecosystem internationally.

We offer the following as a starting point to stimulate further discussion.

1. Promote Universal Health Coverage.

By ensuring the NHS is able to engage effectively internationally, the UK can position the NHS and its values of equity and fairness as the healthcare model of choice for MICs.

2. Mobilise UK health workers.

The UK Government and devolved administrations should continue to invest in schemes that mobilise UK health workers to work overseas recognising the value they hold as a tool for strengthening high quality, equitable health systems in low- and MICs whilst also advancing the UK's national interest.

3. Be clear on donor transition.

The UK Government should publish a framework to guide the transition process from DFID programmes and investments to new relationships which may be led by other Government departments.

4. Lead on global health workforce development.

New centres should be established in each of the UK nations to promote, coordinate and develop the role of the NHS as a leader on global workforce development, in recognition of the estimated 18 million shortfall in qualified healthcare workers globally.

5. Lead on global learning exchange.

The NHS should incorporate explicit objectives to observe and learn from middle-income country practice into health partnership mission statements. We recommend establishing formal forums to disseminate such practice within NHS organisations.

6. Be transparent and strike the right balance where aid and commercial interest intersect.

Further assist the establishment of strong, sustainable, and equitable healthcare whilst highlighting the mutual benefit this brings for both MICs and the UK.

7. Realise the commercial potential of the NHS.

Over the coming years there are likely to be increased opportunities for the UK to provide its advanced health sector skills and commodities on a for-profit or part-subsidised basis to a growing number of MICs. Healthcare UK should engage the UK public sector in discussions about international work through a series of roundtables throughout the country.

6. References

- i** <https://www.gov.uk/government/speeches/open-markets-and-free-trade-will-help-africa-help-itself>
- ii** <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>
- iii** <http://www.ids.ac.uk/project/the-new-bottom-billio>
- iv** <http://www.investopedia.com/articles/investing/022415/worlds-top-10-economies.asp>
- v** <https://www.theguardian.com/world/2013/feb/18/uk-aid-india>
- vi** <https://www.theguardian.com/society/2014/jan/26/nhs-foreign-nationals-immigration-health-service>
- vii** <http://s3.eu-west-2.amazonaws.com/cvid-conservativevisionforinternationaldevelopment/CVID.pdf>
- viii** *Ibid*
- ix** <https://fullfact.org/economy/uk-spending-foreign-aid/>
- x** https://www.bond.org.uk/sites/default/files/resource-documents/uk_public_attitudes_towards_development.pdf
- xi** *Ibid*
- xii** <https://www.bond.org.uk/news/2017/06/the-public-needs-the-bigger-picture-for-uk-aid-to-survive>
- xiii** https://books.google.co.uk/books/about/Aid_Fatigue.html?id=TOErngAACAAJ&redir_esc=y
- xiv** <https://www.theguardian.com/world/2013/feb/18/uk-aid-india>
- xv** <https://www.theguardian.com/global-development/2017/jan/04/uk-among-six-countries-hit-un-aid-spending-target-oecd>
- xvi** <https://publications.parliament.uk/pa/cm201617/cmselect/cmintdev/100/100.pdf>
- xvii** https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478834/ODA_strategy_final_web_0905.pdf
- xviii** <https://www.theguardian.com/global-development/2013/mar/20/uk-aid-spend-important-works>
- xix** <http://www.bbc.co.uk/news/uk-politics-19709321>
- xx** <http://www.bbc.co.uk/news/uk-politics-39658907>
- xxi** <http://www.whyydev.org/owe-uk-aid-national-interest/>
- xxii** *Ibid*
- xxiii** <https://www.thet.org/wp-content/uploads/2017/08/In-Our-Mutual-Interest.pdf>
- xxiv** <http://www.appg-globalhealth.org.uk/reports/4556656050>
- xxv** <http://www.telegraph.co.uk/news/2017/06/05/nhs-told-think-unthinkable-cuts-closures/>
- xxvi** <http://www.bmj.com/content/356/bmj.i6691>
- xxvii** <https://www.theguardian.com/society/2017/jul/14/nhs-holds-on-to-top-spot-in-healthcare-survey>
- xxviii** <https://www.bond.org.uk/news/2017/08/3-trends-in-uk-development-policy-that-brexit-will-accelerate>
- xxix** <http://www.results.org.uk/sites/default/files/files/Leaving%20no%20one%20behind%3F%20Considering%20the%20Impact%20of%20Donor%20Transition%20.pdf>
- xxx** <http://www.bbc.co.uk/news/health-40248366>
- xxxi** <http://www.bmj.com/content/354/bmj.i5169>
- xxxii** <https://www.cgdev.org/sites/default/files/investing-uk-aid-global-skills-partnership-better-health-home-and-abroad.pdf>
- xxxiii** http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf
- xxxiv** <https://www.cgdev.org/sites/default/files/investing-uk-aid-global-skills-partnership-better-health-home-and-abroad.pdf>
- xxxv** <https://www.ncbi.nlm.nih.gov/pubmed/28420405>
- xxxvi** https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284044/ClosingTheGap091013.pdf
- xxxvii** <https://www.cgdev.org/sites/default/files/investing-uk-aid-global-skills-partnership-better-health-home-and-abroad.pdf>
- xxxviii** <https://www.gov.uk/government/publications/cross-government-prosperity-fund-programme/cross-government-prosperity-fund-update>
- xxxix** <https://www.gsk.com/en-gb/about-us/save-the-children-partnership/>
- xl** <http://www.careinternational.org.uk/increasing-access-affordable-healthcare-and-creating-jobs-zambia>
- xli** <http://www.thirstymind.co.uk/international-healthcare/aomrc/>
- xlII** <http://www.appg-globalhealth.org.uk/reports/4556656050>
- xlIII** <http://www.albertoforchielli.com/2015/11/13/the-chinese-healthcare-system-how-it-works-and-future-trends/>



ABOUT THET

Health workers are at the centre of what we do. Without them, there is no health.

Today, one billion people will never see a qualified health worker in their lives. For over twenty-five years, THET has been working to change this, training health workers to build a world where everyone everywhere has access to affordable and quality healthcare.

We do this by leveraging the expertise and energy of the UK health community, supporting health partnerships between hospitals, colleges and clinics in the UK and those overseas.

From reducing maternal deaths in Uganda to improving the quality of hospital care for injured children in Myanmar, we work to strengthen local health systems and build a healthier future for all.

In the past six years alone, THET has reached over 84,000 health workers across 31 countries in Africa, the Middle East and Asia in partnership with over 130 UK institutions.

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