

Five Things the New Health Minister Should Do to Enhance the UK's Global Health Footprint

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As Health Secretary Matt Hancock returns to his role as part of Boris Johnson's premiership, he has an opportunity to make good on the UK's renewed confidence and ambition by drawing on what the new prime minister calls the "best healthcare [system]" to drive improvements in health globally. The UK's Department of Health and Social Care controls its biggest-ever official development assistance (ODA) budget, doubling between 2017 and 2018 to just under £200m, or 1.3 percent of the country's aid allocation. This places the UK's secretary of state for health in a unique position to truly make a difference in countries' journeys towards universal healthcare coverage (UHC), whilst also defending (and making a case for more of) the ODA money his department has been allocated, even to development aid's harshest critics. Here are five things he can do to make this happen, both using his own department's ODA budget and influencing how DFID's majority share is spent.

1. Adopt the Global Skills Partnership for training, attracting, and retaining healthcare professionals—an approach that benefit both the NHS and the originator countries. Over 13 percent of NHS employees are not British, with roughly half of those coming from Asia and Africa. According to a recent review for the [UK's Parliament](#), in every 1,000 NHS employees, 44 are Asian, 21 are African, and 11 come from other non-EU countries, with Indians and the Filipinos making up the largest non-British groups, at roughly 21,000 and 19,000 staff, respectively. With the Brexit uncertainty making the UK less attractive to EU nationals, the numbers of Africans and Asians may well go up. To make healthcare professionals' migration a win-win for both the NHS and the low- and middle-income countries where they usually come from and where they were trained, the minister can endorse and implement a [Global Skills Partnership \(GSP\) model](#) for healthcare professionals ([here](#) is one example of how this model can work in the context of forced migration, as the Syrian conflict has triggered in the Middle East, and how it can be applied to a precious NHS and global health system resource, nurses).

A GSP would respond to concerns arising both from migration pressures and from the NHS's need for trained professionals. In a GSP, the NHS would agree to provide technology and finance to train potential migrants with healthcare skills in their country of origin (e.g., India, the Philippines,

Nigeria, Ghana, and Zimbabwe to list some of the top “exporters” of healthcare professionals to the NHS) prior to migration. The NHS would then get migrants with precisely the skills it needs to meet its requirements and integrate them best upon arrival. The countries of origin (also aid recipients from the UK) would agree to provide that training and in return get additional (potentially ODA-funded) support towards the training of professionals willing to work locally—hence increasing rather than draining human capital at the origin.

This model, [tried and tested elsewhere](#), including between Germany and Vietnam, represents a practical and actionable policy consistent with recent [calls](#) for a more responsible UK and NHS stance toward South-to-North migration of human resources for health.

2. **Boost support for NHS International as an agent of soft power, with particular emphasis on sharing NHS knowledge products and strengthening local institutions and governance, at countries’ request.** Set up in response to [Lord Crisp’s 2008 report](#) on Global Health Partnerships, the NHS International Health Group comprises a range of organisations, including [Health Education England](#); Public Health England; NHS England; the Department of Health and Social Care from England, Scotland, Wales and Northern Ireland; DFID; the Foreign and Commonwealth Office; Royal Colleges; and NGOs such as [THET](#). Some of these institutions have a well-articulated rationale and budget for working internationally (e.g., see here for a discussion from [Public Health England](#)) but the true potential of the group remains untapped. Here are two things the minister can do to help turn this group into a critical contributor to the global UHC movement and, through it, the NHS into an effective soft power in the global health diplomacy stage (see a discussion about this [here](#)).
 - a. **Set up a system of institutional twinings and partnerships between flagship institutions with years of technical and operations expertise in running the NHS and their budding counterparts in LMICs also committed to UHC.** The wealth of experience of NHS England in commissioning services and procuring technologies (see [here](#) for our recent analysis of procurement in Africa and South Asia); of the Care Quality Commission in regulating providers; of Health Education England in training professionals; of NHS Digital in managing a universal health information system; and of NICE in reviewing value for money of pharmaceuticals and devices is directly relevant to the functions healthcare systems in countries transitioning away from aid (such as South Africa, China, Ghana, India, Indonesia, and Nigeria) require to run their own systems. It is also at high demand, as evidenced by requests for support from the health authorities of some of these governments. And whilst the newly boosted [cross-departmental Prosperity Fund](#) is meant to service many of these MICs, the implementation modality it has adopted—outsourcing large contracts through big multinational consultancy firms which then subgrant to consultants—may be operationally easier, but it dilutes or explicitly excludes from delivery the UK’s own public sector or smaller think tanks and research outfits. The DFID-funded [HMRC-based Tax Capacity Building and Tax Expert Unit](#) may be worth emulating with NHS expertise in quality regulation, information management, professional curricula development and delivery, and [strategic purchasing and procurement](#) all provided at countries’ request and with a formative evaluation process from the outset to course correct. Such an approach can help build long-term relationships with healthcare systems around the world [whilst also strengthening the UK’s](#).
 - b. **Encourage the NHS and its support agencies to share knowledge products proactively as global public goods with healthcare professionals working in the poorest countries.** The health minister needs to relieve pressures on the NHS’s non-departmental public bodies and

arm's-length bodies to generate income, at least where there is significant potential for reputational and diplomacy gains for the UK and a poor track record of successful public body-led commercial endeavours (e.g., see [here](#) for a short account of NICE's efforts and an [alternative vision](#) of what could have been). For starters, healthcare institutions should lift the inconsistent-with-ODA and ultimately unprofitable restrictions on the poorest countries accessing [global public goods](#) developed with taxpayers money and through the volunteering of NHS professionals and academics sitting on expert committees. The [British National Formulary](#), including the most valuable paediatric edition, and NICE's [Clinical Knowledge Summaries](#) are now both geo-protected and inaccessible from all countries, including those where British aid is invested with the aim of improving health outcomes. Instead, old worn paper versions of the BNF are shipped as [charity](#) around the world, oftentimes sold for a margin. Knowledge of what works best and for whom, as conveyed through clinical guidelines developed by NICE, can be [adapted](#) to local settings and serve as a powerful driver for improving the quality of care of poor people. Instead, all NICE products are [IP protected](#) and require non-UK non-EU public sector users—including national governments such as ministries of health and social insurers in India, Ghana, and South Africa—to pay NICE a fee for accessing the material.

The health minister can use ODA to pay for lifting such restrictions, or better yet, require NICE and other arm's-length bodies to make their knowledge products proudly available to those serving the poor and the sick the world over. With the [US administration recently withdrawing support](#) to a similar federally funded resource, such a move by the UK government would be felt and appreciated.

3. **Work with DFID to set up a What Works Centre for Best Buys in Health, starting with health-care commodity procurement and health taxes.** There is a strong case for [sharing evidence](#) of what works as well as the methods and processes (including governance and technical capacity) for locally generating new or adapting such international evidence to different settings. The health minister can use his department's experience to help DFID start in a small and targeted fashion, and scale up only if the value of the initiative is proven and [demand from LMIC policymakers is established and growing](#). Whilst what works in the English NHS (or even parts of the NHS) [may not work](#) in other parts of the UK let alone other countries, including ones much more resource constrained than the UK with different cultures and different politics, there are areas with potential for significant efficiency gains or income generation where evidence can be collated, adapted, and applied to make a difference. Two such areas are commodity listing and pricing, and "sin taxes":
 - a. **Help DFID set up a What Works Centre for development starting with a focus on healthcare and healthcare commodities.** Assessment of value for money of pharmaceuticals and devices is a prerequisite for NHS reimbursement. NICE is indirectly responsible for roughly £1.5-2bn year on year through its evidence-informed assessments and recommendations for use (or not) of interventions and technologies in the NHS. Informed by the National Institute for Health Research (more on this later), NICE uses Health Technology Assessment to drive better value for the NHS's limited budget. In fact HTA was [endorsed by the World Health Assembly in 2014](#) as a means of improving health system efficiency, equity, and access with a number of LMICs setting up similar processes. However, major global procurers of medical technology—such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and Gavi—and norm-setting agencies such as the WHO (see our [recent findings and recommendations](#) on WHO's norm-setting and the absence of economics) do not use HTA in identifying best buys they go on to fund (or, in the case of WHO, recommend for funding) wholly or in part (in the latter case, the remainder is country monies).

Take the GFATM, which spends over £2bn every year procuring commodities. Individual technologies such as nets, ARVs, and TB drugs and diagnostics are not dissimilar in nature to the commodities NICE assesses, each one with different clinical effectiveness and unit costs. The British government just committed £1.5bn to GFATM. The health minister should work with his counterpart at DFID to [help GFATM implement processes similar to those the NHS applies to ensure UK taxpayers get value for their healthcare](#) money using the methods, processes, training, and actual analyses produced by DFID's What Works In Global Health Centre.

- b. **Share existing—and help generate new—country-specific evidence on the efficiency and progressive distributional impact of health taxes with ministries of finance.** There is growing evidence on the fiscal and health benefits (and progressivity when assessed over a long enough time frame) of taxing tobacco, alcohol, and (less so) sugar. (This fight is not yet won in the UK, at least for [taxes on sugar](#).) Match this with some form of soft earmarking (the kind treasuries may not dislike too much!) to fund UHC through, for example, lifting user fees for primary care clinics in the poorest parts of the world, and a country may be well on its way to sustainable UHC. Sounds too good to be true? The [Philippines](#) almost doubled its UHC budget in a single year after its parliament passed laws taxing tobacco and alcohol. According to a [recent Commission](#) co-chaired by Michael Bloomberg and Lawrence Summers, “if all countries increased their excise taxes to raise prices on tobacco, alcohol, and sugary beverages by 50 percent, over 50 million premature deaths could be averted worldwide over the next 50 years while raising over US \$20 trillion of additional revenues in present discounted value.”
4. **Help countries set up a national research infrastructure explicitly to service their healthcare systems, using NIHR as a model and the NIHR Global Health Research fund as a means for researching and evaluating the relevance of such an approach at country level.** In a 2015 [report](#), RAND concluded that if just 12 percent of the potential net benefit of implementing the findings of a sample of only 10 studies carried out by the National Institute for Health Research HTA programme, for one year, was realised, it would cover the cost of the whole programme from 1993 to 2012. Despite calls (see [here](#) for the recent WHO-led R&D Accelerator proposals) and commitments, very few LMICs consistently fund research to service the needs of their own healthcare systems. Such research could take the form of assessments of what works in local settings as discussed earlier, pragmatic clinical trials, disease and technology registers to drive quality and efficiency, epidemiological and costing studies, clinical audit, evaluation of alternative approaches to procurement, and methods studies [looking at healthcare system productivity and local definitions of value for money](#). NIHR's programme in the UK is an excellent example of a demand (in this case, NHS) driven research infrastructure, building local capacity and generating information the NHS needs to monitor and improve its performance. In addition to disease- and technology-specific calls, the NIHR Global Health Research Fund should launch a programme dedicated to generating evidence of the kind NIHR generates to support the day-to-day functioning of the NHS, helping inform the decisions of NICE, the national screening committee, and the joint committee on vaccination and immunisation. Without such evidence, healthcare systems cannot progress towards and sustain UHC.
5. **Reduce fragmentation, increase coordination and scale, and articulate a strategic vision, jointly produced with LMIC academicians and policymakers, for the department's multiple policy and research ODA funds.** There is a [multiplicity](#) of ODA-funded Department of Health-managed pots and programmes, including for Global Health Research (managed through NIHR) and Global Health Security. There also are many cross-departmental research and operational funds, some disease- or technology-specific related to health. Together this contributes to a fragmented pic-

ture, making it hard to make a case for the value for money of the “totality” of the UK’s aid allocation, as concluded [elsewhere](#). The UK health minister should review and try to [consolidate](#) the various research and policy funding pots, whilst also setting out a clear vision of what success would look like. This should be done through a consultative process including select policymakers and academe from LMICs whom the ODA funds are meant to benefit. Such an approach would make assessing progress (and the jobs of the National Audit Office and the Independent Commission for Aid Impact) easier and realising the vision more feasible.

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