The panjandrums of global health

Richard Horton's Comment (July 13, p 112)[1] captures powerfully what is still wrong with the way external cooperation is provided to developing countries' health systems. This is despite the rhetoric and promises of the Rome, Paris, and Accra Declarations—the so-called Three Ones initiative, and most recently the Global Partnership for Effective Development Cooperation (GPEDC), launched in Busan, end of 2011. Horton states that Busan lacked the clarity of Paris and fudged the responsibility of donors; "it was a step backwards, not forwards, for development cooperation", he noted.[1]

Reflecting on Horton's Comment, Ngozi Okonjo-Iweala, cochair of GPEDC and Nigeria's Minister of Finance, suggests[2] that, instead, Busan saw donors reaffirming their Paris commitments and not stepping away from them.

I am sure that donors and other partners did reaffirm their commitments at Busan; but there is a huge gap between what is promised at a global summit and what is then subsequently delivered in-country. As Horton notes, post-Paris there has been a severe loss of direction and momentum in improving the quality of how cooperation is delivered and a rolling back of previous progress. From a country perspective, it is hard to disagree, and a recent report[3] sets this out more broadly than the health sector.

So what do we really need to do to breathe life back into the principles of development effectiveness? How do we make them real at country level, beyond the rhetoric of the high-level summits?

I suggest three things are still needed: first, leadership from a credible and legitimate local champion who has leverage with all partners and can help ministry counterparts to broker good behaviour (given the new role of the UN in GPEDC—which was missing from Paris and Accra Declarations—this could be a key deliverable for WHO and the UN Resident Coordinator). Second, a single local forum for accountability that allows progress to be tracked, provides mutual accountability for commitments, and reports back to the global summits; and third, a simple traffic-light based road-map that clearly tracks partners' adherence to their commitments, provides the focus for the local accountability forum, catalyses a more robust local dialogue on development behaviour, and forms the basis of progress reports to summit meetings.

I am aware there is progress towards some of these, but not all, and it has been painfully slow. Meanwhile, we lose the clarity, focus, and energy that the Paris approach gave us, and we risk allowing an essential approach to improving development quality and effectiveness drift into the waste-bin of aid fads.

I am the former team leader for the Three Ones initiative at UNAIDS.

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Clinical leadership to improve health outcomes

Richard Horton (Sept 14, p 925)[1] presents ten core principles for future hospitals from the report of the Future Hospital Commission.[2] Although these principles and corresponding recommendations for collaborative, coordinated, and patient-centred care targeted British hospitals, they might be relevant in other countries as well. However, we believe Horton leaves one important question unaddressed. As the Commission emphasises, there is an urgent need for effective clinical leadership in the future hospital,[2] but do we have it?

Evidence suggests[3] that the health profession falls short of providing leaders with the full complement of competencies so urgently needed for finding sustainable solutions to the wicked problems endemic in our health systems. Clinical leaders must be trained to recognise ailments in the organisational systems they rely on to deliver effective preventive and therapeutic services. We have been doing this in medicine and public health for years, adopting and adapting quality improvement approaches—such as the managerial concept Lean Six Sigma borrowed from manufacturing and engineering specialties.[4] We need to do a better job of diagnosing health-care system failures and applying effective strategies for rapid process improvement.

We suggest an eleventh principle: a culture of leadership that embraces a commitment to building problem solving and implementation capacity, and focuses on organisational outcomes. We will build communities of practice that share and apply problem solving approaches, results achieved, and lessons learned.[5] It is the only way our health systems, and the people they serve, will all enjoy sustainable positive outcomes.

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Evidence based medicine—older, but no better educated?

In 1995, *The Lancet* published the results of an audit assessing the extent to which general medical inpatients were managed in an evidence-based manner.[1] David Sackett conceived the project in response to the assertion that as few as 10–15% of decisions relating to the care of medical patients were based on good evidence.[1,2] He and his team reported that, over a 1 month period in a large tertiary teaching hospital, 82% of acute medical patients received treatments based on evidence.[1]

15 years after Sackett's landmark study,[1] we repeated this audit in the same department of the same hospital in Oxford, UK. 121 general medical patients were admitted under the care of our team during a 1 month period in 2010, compared with 109 in Sackett and colleagues' paper.[1] The method echoed that of Sackett and colleagues, placing primary interventions into one of three categories: intervention based on evidence from one or more randomised controlled trials or systematic reviews, intervention based on convincing non-experimental evidence, or intervention without significant evidence.

83% of patients were deemed to have received evidence-based care (table). This is strikingly (and perhaps disappointingly) consistent with the 82% reported by Sackett and colleagues.[1] It is also consistent with other studies in North America,[3] Sweden,[4] and the UK,[5] which report that 73–84% of patients received evidence-based care.

22% of our patients' treatments were based on evidence from randomised controlled trials, and 61% were treated according to convincing non-experimental evidence. Sackett and colleagues reported 53% of treatments were supported by randomised controlled trial evidence and 29% were based on convincing non-experimental evidence.[1] This possibly represents the ongoing importance of logic and common sense in medical decision making, and not a failure of evidence.

There seems to have been very little change in the percentage of decisions based on good evidence during the past 15 years, despite more trials and a much wider appreciation of evidence-based medicine. Medicine appears to have grown older, but no better educated.

	Patients (%)
(I) Evidence from randomised controlled trials	27 (22%)
(II) Convincing non-experimental evidence	74 (61%)
(III) Interventions without significant evidence	20 (17%)

Table: **Level of evidence for primary treatments received by general medical inpatients**

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Research publication in India faces new challenges

Listed in low-income countries until 2009, health researchers in India had substantial advantages in accessing research articles and submitting reports for publication with low processing charges for international publication. In recent years, India has progressed from being a low-income country to a middle-income country in the Health InterNetwork Access to Research Initiative—known as HINARI—list (based on World Bank data, UN's list of least developed countries, and the Human Development Index). This promotion has deprived Indian health researchers of the privileges they had availed earlier as a researcher from a low-income country especially in getting the waiver for publication charges in international journals.

The current scenario is hampering health researchers in India in portraying their work to the global audience because of insufficient fundings. Health institutions and researchers need to overcome this situation. Dearth of funding mechanisms to support the publication charges is the most evident issue to overcome. Policy makers should prioritise and focus on the dissemination of the scientific work done in India across the globe.

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Department of Error

Clark F. Reforming the Russian Academy of Sciences. Lancet 2013; **382:** 1392–93—In this World Report (Oct 26), Vladimir Zhirinovsky's name was misspelt. This correction has been made to the online version as of Nov 1, 2013.