HOUSE OF COMMONS

International Development Committee

Oral evidence: Health Systems Strengthening, HC 948

Thursday 10 July 2014

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Written evidence from witnesses:

- Nice International
- Global Fund to Fight AIDS, Tuberculosis and Malaria
- Department for International Development

Watch the meeting: Thursday 10 July 2014

Members present: Sir Malcolm Bruce (Chair); Fiona Bruce; Sir Tony Cunningham; Fabian Hamilton; Jeremy Lefroy

Questions 57-148

Witnesses: Dr Kalipso Chalkidou, Director, NICE International, Dr John Howard, Chair, International Forum of the Academy of Medical Royal Colleges, and Dr Michael Johnson, Head of Technical Advice and Partnerships, the Global Fund to Fight AIDS, Tuberculosis and Malaria, gave evidence

Q57 Chair: Good morning and welcome to this evidence session on health systems strengthening. Thank you very much for agreeing to come in and give evidence to us. I wonder, for the record, if you could introduce yourselves.

Dr Johnson: Michael Johnson. I am the head of the Technical Advice and Partnerships Department in the Global Fund to Fight AIDS, Tuberculosis and Malaria. Good morning.

Dr Chalkidou: I am Kalipso Chalkidou, and I am the director of the international programme at NICE—the National Institute for Health and Care Excellence.

Dr Howard: Hi. I am John Howard. I am a GP from Surrey and I am Chair of the Academy's International Forum, which is the collation of all the UK medical and nursing Royal Colleges' international departments.

Q58 Chair: Okay, thank you very much. We have had quite a bit of evidence—obviously some of it critical, some of it supportive, some of it contradictory—about DFID's role in systems strengthening. From your experience, have you detected changes in the

approach of DFID to health systems strengthening over the last few years? Do you see a difference or a change of strategy that you can identify?

Dr Johnson: I cannot speak quite as much to the change, but maybe I can make a couple of comments about their role. So, thank you very much first of all. Mark Dybul was very keen to be here but was unable to, and really appreciates the opportunity. I also want to start off by expressing tremendous support and respect for your Government's support of the Global Fund. It came through at a very delicate and important time, and things are going in a very good direction right now.

As far as the DFID role, we have representation from the UK on our board and we have a DFID person serving on the Strategy, Investment and Impact Committee of the board. This is a key committee that helps design the direction of the programmes, the way they are evaluated, etc. Through those channels, we are also seeing DFID officers in the field, in countries where the programmes are implemented, being involved in supporting the process of how the money gets distributed in several ways: first, by being on country co-ordinating mechanisms—CCMs—and, secondly, by working with host Governments to support host country contributions, and to co-ordinate the Global Fund investments with other resources that are coming in, either from other donors or more importantly from the host country itself. We see DFID as highly involved in the Global Fund activities—both from a political, and from a programme and technical perspective.

Dr Chalkidou: I just want to add that we have only been doing international work for about six years now. We at NICE still consider ourselves health care professionals as opposed to development consultants. However, the reputation of DFID is tremendous. Not only does it directly support health systems strengthening initiatives—which I can go on to define if you like—but it also leverages funding from other donors to do that. To me, that is even more important than the direct support.

Dr Howard: Royal Colleges have been involved in international work for a very long time but actually, like a Venn diagram, our sphere has not until recently quite got into DFID's sphere. I think this is because, until more recently, they probably considered UK medical and nursing Royal Colleges as being something different from what they want to support. I think that is changing, and I have seen evidence that it is changing. We have had some very helpful discussions more recently. They have helped us contribute to things such as our volunteering statement from the academy.

Q59 Chair: We might have some more questions about that later on. What emerged from our first evidence session was that in its bilateral programmes, DFID was quietly continuing the work of strengthening health systems. It seemed to generally appreciate that that was what was happening. First of all, do you agree with that? I think the counter to that was that they were not necessarily quite so assertive in their relationship with the various global funds in ensuring that they were delivering on strengthening systems. Perhaps to take the first part, do you accept that DFID is quietly is building those systems, especially in its bilateral programmes?

Dr Chalkidou: I would say so, yes, absolutely. From our limited experience in working with policymakers in various countries, the feedback we are getting is that DFID has a good reputation and is very supportive of their own priorities and the priorities of the country as set by the local policymakers.

Q60 Chair: However, in your own submission you did say that "messier governance strengthening and institutional capacity building initiatives" tend to get neglected by DFID. So, how does that piece of evidence fit in?

Dr Chalkidou: I meant that they get neglected mostly through their work with multilaterals. They get diluted down. It is tricky because multilateral support has benefits, and there is empirical evidence to show that it works, and works well—less overheads and all these things. So, I think that not many people are advocating a return to bilateral alone, and pulling money out of the multilateral channels. The Global Fund has done a great job so far to the objectives it has set.

Q61 Chair: But it is much easier to say that we are going to deal with HIV/AIDS than it is to say that we have strengthened a system.

Dr Chalkidou: Precisely, because it is measurable. Health systems strengthening is a bit like a black hole. I think that is what drove the pendulum back towards specific priorities. People would say, "Anything we cannot do, it has all got to do with the system." There are very tangible things we can do to strengthen systems. We can look at our own system here in the United Kingdom: the National Health Service. That is what policymakers look at. So it has got to do with governance; it has got to do with institutions; it has got to do with making decisions for which you can be held accountable, that are made transparently, and where your committees have declared their interests. When Governments adopt these kinds of policies that to me is a very tangible measure of health systems strengthening. It is not this sort of vague notion anymore that scares off the donors.

Q62 Chair: Michael Johnson?

Dr Johnson: Yes, I would love to make a comment. Thank you very much. I would like to try to take a little bit of the oxygen out of this debate about health systems strengthening versus disease-specific work, because they really go together. They really go together. It is not a "one or the other" thing. There are a couple of examples from the Global Fund's experience on this.

First of all, if in our overall portfolio you look at what is called an HSS grant, in the history of the Global Fund, it is approximately 10% of what we put out. It is about 3 billion over a denominator of close to 30 billion. However, if you go through the grants and you actually look and see what is in an AIDS grant, a TB grant or a malaria grant—and you look with the lens of what a reasonable person would say is health systems strengthening: training of health systems professionals; health information systems to collect data; procurement systems to get drugs to people—those are all things that are being funded in a big way through the Global Fund.

So I would say—and we have data to show this, and I believe we put it in our submission—that three or four times more than what we call health systems strengthening is in fact health systems strengthening. We probably need to do a better job of teasing that out and communicating that. How does that show up in a real country example? In Tanzania, for example, there is a system called the District Health Information System 2, developed by the University of Oslo in Norway. That system might be funded through an AIDS grant—which it has been—but it is an open-source software system. So a local

ministry, ministry of health, civil society, DFID or other bilateral can take that system and, for pennies on the dollar, add modules that allow it to collect data across all kinds of diseases. We have many stories like that.

Chair: Can I bring in Jeremy Lefroy to pursue that point?

Q63 Jeremy Lefroy: Yes, thank you very much. You have half-answered the question that I was going to pose, which was about the fact that some witnesses we had earlier suggested that systems strengthening work by multilaterals such as GAVI or the Global Fund tends to be driven by narrow, disease-specific priorities. The kinds of examples you have given indicate that you would not particularly share that view. Do you think the Global Fund has moved over the past few years from being very focused on disease-specific interventions and not really going wider at all, to understanding that, in order for these to be sustainable, you have to have a strengthened health system?

Dr Johnson: There has been a shift. At a couple of different times, there have been more specific changes to provide emphasis on health systems strengthening. I could get the specifics to you of which year and which changes were made. I would add that while it has resulted in movement of money into these pots called health systems strengthening, I think the bigger impact are these examples of where something that is funded, and applies to, and helps to support an AIDS programme or a TB programme or a malaria programme does in fact have a very positive what you might call collateral effect. I do not think it is by accident; it is through local leadership. As I said, this is where DFID, other bilateral Governments and most importantly host country Governments can take these investments and make them much bigger.

There has been an increase, both in intent and in policy, in what the Global Fund is doing in HSS, but I would not say that this is to create a huge pot and take away from the disease-specific interventions. Instead, it is to leverage more and create greater partnerships. For example, we are doing this through a recent agreement with UNICEF, where we are continuing to put money into AIDS, TB and malaria, but creating opportunities for them to come to the table in-country and see where resources can be leveraged—for example, by adding zinc or adding antibiotics, or adding things that cost pennies, on to an infrastructure that is being primarily funded for AIDS, TB or malaria, and in this case most often for malaria.

Q64 Jeremy Lefroy: In Sierra Leone, we saw UNICEF very much involved in bed net distribution through the national health system, which was presumably considerably funded by DFID and the Global Fund. When you are designing a specific programme with a host country Government, is the health systems strengthening element focused on or is it just a by-product—an adjunct? Is it there at the heart of the discussions, and how is that done formally—how is that captured?

Dr Johnson: That is a great question, thank you. We are increasingly doing it formally. It is involved in what we are calling in the Global Fund the new funding model. This is creating a process of what we are calling country dialogue that ensures—and we check on this—that different disciplines and different perspectives are brought to the table in how a Global Fund proposal is put together. Our fund portfolio managers monitor this and make very frequent trips into country. So it is explicit now that people who have a knowledge

and an interest in health systems strengthening, along with many other things, all have an opportunity to feed into what we call a concept note—which is basically the name for an application.

Q65 Jeremy Lefroy: So, when you are doing an evaluation of a particular programme, will that also come into it? In terms of particular programmes such as the intervention we saw on bed net distribution—or perhaps in my case, as I am chair of the all-party parliamentary group on malaria and neglected tropical diseases, a programme such as we saw in Uganda with health workers going and tackling the disease at an early stage through diagnostics and provision for children of paediatric formulations—is the evaluation looking at how this has enabled the strengthening of the local and national health system? Possibly not now, as we do not have the time, but subsequently could we have in written form some examples of these evaluations?

Dr Johnson: Sure. Let me talk near term and then longer term. The near term is a little easier to answer. When concept notes or applications come in from the country, they go through an independent evaluation that includes a very strong lens of health systems strengthening, along with AIDS, TB, and malaria. I could get you the composition of what we call the technical review panel, but it very substantially includes HSS experts: cross-cutting people. Then at the senior level it goes to the secretariat. In fact, just yesterday we had a grant approvals committee. Jason Lane from DFID was there as well, as part of our partnership that comes around to look at these grants. We actually analysed how much is HSS, how much is AIDS, how much is TB, and how much malaria. So there is a front-end analysis of what the portfolio looks like in an effort to balance an individual grant and also to balance the portfolio overall. Then we feed that back to the country.

In the longer term—and I think this is in some of the submissions you have received—the challenge is measuring what a strengthened health system is in the long term. We are working with WHO and other partners on a service availability and readiness assessment. This is a standardised survey, which we are having considerable input into, that goes to clinical sites and assesses several aspects of their readiness to provide service. Do they have the drugs ready? Do they have the laboratory availability? Do they have the financial systems in place, etc.? So that is a longer-term evaluation and we are keen for DFID to be involved in that, and to help us, and to participate in how that unfolds. The centre of that is not just AIDS, TB and malaria. Its overall initiative and thrust, if you will, is from WHO.

Q66 Jeremy Lefroy: Thank you. Just finally, Chairman—do you find any resistance from any quarters from people who simply say, "Look, we want to be focused; we want to get the maximum results in terms of lives saved. Anything that goes beyond that is not our job in the Global Fund," either from the people who work within the Global Fund, or indeed from those who support the Global Fund, or the wider health community?

Dr Johnson: The way you phrased it, I would say no. There is certainly a spectrum of people's views on it. When I say "people's views", it is mostly our board. We have a 20-member constituency-based board, and there are different views on the board—and you have a voice on that. But what we are trying to do, and, as I mentioned earlier, what we are doing and will push harder to do a better job of communicating, is to take a position that it does not have to be either/or. There are a lot of things done that explicitly,

clearly and in the short term, serve to improve the treatment and prevention of AIDS, TB, and malaria. However, with just a little bit of additional resource—and more than resources, I would say leadership and vision, which can come from many sources—these things can be taken and expanded greatly. I hope we can get to that place. Sorry to be long-winded, but fundamentally the answer to your question is that we do not get extreme pushback in that way. We do have to be balanced, because we have a number of voices on our board.

Q67 Fabian Hamilton: My question is mainly directly at you, Kalipso. I wonder whether you could tell us whether you think that channelling a greater proportion of health aid through multilaterals inevitably means that less will be spent on systems strengthening.

Dr Chalkidou: I do not think it has to be the case. I think it probably has been the case. I do not subscribe to the trickle-down effect of health systems strengthening—that if we fund a lot of TB and HIV clinics, then the systems will get stronger necessarily. I agree that there may be positive externalities but there may also be negative ones. So, when you pay a good fee to health care workers to man HIV clinics, they will not be looking after a woman giving birth next door. There is some suggestion that there have been these sorts of trade-offs indirectly.

There are also trade-offs at the central level. I have been talking to the head of health policy and planning in the government of Sierra Leone. One of his major questions he put to me—which is very similar to the questions we are trying to help the National Health Service to address—was, "How do we bring things together? We have got vertical problems. We want to set up our national health insurance scheme in this country. We want to start running it slowly. Okay, we are weak governance-wise. How do we do that?" Because in terms of sustainability, we do not want to have an aid industry for ever. We want countries to take control of their growing budgets and spend them, so we need to think about convergence. I would argue that the new funding model is a great opportunity for the Global Fund to make more of the money that is given to it in terms of health systems strengthening.

For example, if you look at the governance of the Global Fund, a series of studies and recommendations have been made, such as the market dynamics report back in 2011, commissioned by the board and endorsed by the previous board, which recommended that a health technology assessment agency is set up to support the decisions made by the Global Fund in terms of its priorities and where the money goes to, or the more recent report on value for money by the Centre for Global Development. There is a lot of material there I could share with you if you are interested in terms of data. The Global Fund spends roughly half of its budget in buying things—commodities, stuff—and they have got 400 to 450 individual technologies ranging from nets, to drugs for HIV, to condoms, to whatever you can think of. These commodities are just put forward with no evaluation of comparative clinical and cost-effectiveness. It is just a list of things that people pick from. You have manifold differences in terms of value for money between the most and the least cost-effective interventions. So, for instance, there is data to show that the most cost-effective intervention for the prevention of HIV is 1,400 times more cost-effective than the least cost-effective one.

Q68 Fabian Hamilton: I am sorry—1,400?

Dr Chalkidou: 1,400 times. That is in the disease control priorities report. So I can get you a lot of information around that. There is the potential for doing what we are doing now in our NHS, where we look at pharmaceutical products and we look at technologies and we say, "Well, some things we cannot afford," or, "For some things we would perhaps like the price to be a bit lower." Why can we not do this with our aid money? I cannot see the difference.

Q69 Fabian Hamilton: Do you think that DFID should act to ensure that the Global Fund and GAVI, for example, do more to strengthen health systems? If so, what should they actually do? Should we seek to reform them or just send them less money?

Dr Chalkidou: I do not know. I am not sure what the right answer is and I think that is a big responsibility. The Global Fund has done a great job and so has GAVI. They have done what they were asked to do; they were not set up to strengthen health systems. They were set up to tackle these three conditions and they have done this very well, and they have saved people's lives, so you should not judge them for that.

Q70 Fabian Hamilton: So it is not their purpose.

Dr Chalkidou: That is right. However, I think that DFID has great knowhow and also great funding power to leverage and change them. The new funding model is a great opportunity. We have been working with the Global Fund to see where we can find opportunities to introduce this type of capacity-building on the ground. When the Global Fund leaves countries because they have become richer—when countries graduate—what is the capacity on the ground for policymakers to use their own budget to continue funding good-value-for-money interventions? That is what health systems strengthening is, as far as I am concerned: empowering people, and allowing them to use their own money better. That is the future of aid, which is effectively—hopefully—a non-future for aid as countries become richer.

Q71 Fabian Hamilton: Yes—aid that puts itself out of business. We have been told that primarily vertical programmes can strengthen health systems through what is called diagonal effects. I wondered if you could just explain what that was, and the merits and limitations of that approach.

Dr Chalkidou: I think what Michael said is probably what this refers to, but I must say that I get confused. I am not sure what "diagonal" is. I can understand vertical; I can understand spill-overs; and I can understand some things we need to do—epidemics need to be tackled—but I do not know what "diagonal" means.

Q72 Fabian Hamilton: John or Michael, do you know what "diagonal" means?

Chair: It is a piece of academic ingenuity, I think.

Dr Johnson: It is a concept. I think it was first written in a publication—maybe in *The Lancet*—by Julio Frenk and others. I do not think it is easy to say, "It is this and not this." I interpret it as much more of a conceptual issue, which I am trying to support, where we do not get into this fight between either/or. Both are important. Both are absolutely important, and there are ways that they can be approached so that the interventions in a

vertical way are leveraged, and interventions in a horizontal way are more accountable by being tied into some of those vertical results. That is my best understanding of it. It is a middle ground between the two more extreme approaches.

Q73 Fabian Hamilton: So no-one can really explain the merits or limitations of the approach.

Dr Johnson: We are doing that in some ways by being cognisant of taking these very disease-specific interventions and positioning them, and seeking leverage so that they can be applied in a more general health-systems-strengthening way.

Dr Howard: No, I cannot help you with "diagonal". As clinicians, we work in the swampy lowlands of horizontal stuff.

Fabian Hamilton: It sounds dangerous**.**

Dr Howard: It is the other part of the equation, which is about the quality of the clinicians right from the very lowest level of primary health care community workers right the way up through to the specialists in hospitals. It needs to be seen to be part of a whole continuum. So, from our perspective, the biggest area where we see DFID helping us is in being able to provide local support to help strengthen collaborative relationships between clinicians in-country and those from outside. We need to be able to strengthen the local management and infrastructure—because generally they are pretty weak and things just do not get done—and to be able to maintain them. We need to be able to facilitate and commission specific training needs where they are identified. As you know, in the UK we respond very positively to those in a very flexible and inter-professional way. But it is all about quality. The important thing is improving that, because without the quality of the clinicians it is no wonder that programmes do not work.

Q74 Sir Tony Cunningham: I have a couple of questions for you again please, John. We have been told that public health and primary care are often neglected in developing health systems. What would your top one or two priorities be for DFID in seeking to rectify that?

Dr Howard: As I mentioned right in my very first statement, it is really nice to say that we are just beginning to engage. I remember when Nigel Crisp was first scoping his report, he said to me, "John, actually the Royal Colleges are not even on the radar of DFID. They think they are arcane, self-serving membership institutions." However, we are not. We have a long record of wanting to work with colleagues. We have huge diaspora groups within our Royal Colleges, and they provide a superb mentoring role for inward training and also a lot of volunteering opportunities outside. They are largely untapped.

We also have a huge groundswell from all of our younger clinicians—nursing, midwifery, doctors, paramedics; everything—who are really keen to be involved. However, they do not really have any structured, managed process for that. They certainly do not necessarily have the opportunities to be released for things. The BMA have been very helpful, and there are some sound examples of where they can be released. But it is a huge challenge actually getting released, particularly in the current climate. So I would think that DFID are really helpful in being able to facilitate things and being able to understand the perspectives of clinicians—not just those of very low primary health care

workers, because obviously in primary health care you are looking at health promotion, prevention, interventions and ongoing palliative care. That is one of the Cinderella things that is sometimes lost.

I think public health has almost been forgotten. It used to be our biggest strength. Public health issues, and the clinical application of those, have to be brought into primary care programmes, so that public health clinicians are working with other primary health care clinicians and vice versa. It needs to be more integrated. We recently held a meeting where we were looking at collaborative work from all of the Royal Colleges, including nursing and midwifery, and how we can actually support curricula that are very generic right the way down.

Q75 Sir Tony Cunningham: So progress is being made.

Dr Howard: Progress is being made, but this will be large pieces of work. Remember, we are all volunteers. We do not get paid for this; we are doing this voluntarily. If this was resourced significantly, then we could do a huge amount.

Q76 Sir Tony Cunningham: My second question: we were cautioned in our first evidence session that community health workers should not be seen as a magic bullet, although when I was in Ethiopia I was very impressed with the work that was going on there. What would you identify as the main workforce obstacles to systems strengthening?

Dr Howard: From the clinicians' point of view, it is lack of them. That is the first thing. The global health workforce crisis has been clearly identified in the literature and also by Lord Crisp and his work. So it is the actual numbers game that is the thing. It is also the isolation that people work in and the lack of feeling involved, of communication and of ongoing professional development—let alone the training structures locally, which tend to be very weak.

This is again where I feel that DFID can be very helpful in encouraging and facilitating collaborative partnerships with local health care training providers, not just for doctors and nurses but also all health care workers—and the ongoing quality assurance and continuing professional development that comes out of this. It raises profile, prestige, and morale locally, and it does the same for our own colleagues from the UK who are actually feeling as if they are doing something worth while in supporting their colleagues. They are not trying to take over and do things; they are trying to provide ongoing support. We know through our programmes that these relationships that can be established are enduring—they are lifelong. We play the long game, and we see the ups and downs of political and financial turmoil, but at the end of the day we are still working closely with colleagues we have worked with for 30 years.

Again, that is one of the strengths that DFID could really encourage. I think the Health Partnership Scheme is a good way to start that. Unfortunately in the first round, UK Royal Colleges have been singularly unsuccessful in their applications—again, perhaps for the reasons I have stated earlier. However, perhaps in the second round the emphasis will change. I hope so.

Dr Chalkidou: I just wanted to say that we also work very closely with the colleges. In fact, NICE in the UK relies on clinicians in the UK to volunteer their services to help the

National Health Service make better decisions. We find that these clinicians are very keen to work with us internationally as well. Without them we would not be able to offer very much internationally at all. I will just mention what I think is a fairly innovative project that DFID is funding that has just started: this will look at the Cuban model of medical education, with its emphasis on primary care and community service by clinicians and by doctors, not by community health care workers. We are doing some work with the Government of Cuba in conjunction with the FCO in Cuba, and also with the School of Public Health in Havana and the medical school and the Government of South Africa.

The Cubans have traditionally supported the education of health care professionals and doctors in Africa. Now that they are perhaps becoming a bit shorter of money, they are trying to get remuneration for that service. So it has become more important to show evidence that their model works. It is a very innovative model, working with the Pan American Health Organization, the Cubans and Governments from Sub-Saharan Africa—starting in South Africa—looking to see how African doctors trained in Cuban universities in Africa operate: where they are; whether they go to the West, because that is the major problem with the western model of education; whether their skills are fit for purpose as doctors as compared with the community health care workers model; whether they are good value for money; and whether they can help communities through primary care and prevention. That is a pretty exciting project.

Dr Howard: May I ask you a question? Is that possible? Am I allowed to ask questions?

Q77 Chair: We will tell you when you have asked the question whether we will answer it.

Dr Howard: One thing we found bizarre from our perspective is that when we were looking at developing more broad-based curricula to be able to support a whole range of health care workers, and a style of curriculum to help specific speciality ones, we had no resources and no funding for this. We were always a bit amazed that DFID give a lot of foreign providers, such as Johns Hopkins and Deloitte, what seems like millions, yet nothing seems to come to UK providers. I just wanted to ask about that.

Chair: We will be asking that ourselves in a minute, I think. You have anticipated that. We will come to that.

Sir Tony Cunningham: It is on the agenda.

Q78 Fiona Bruce: This is initially a question to Ms Chalkidou. We have received evidence that shows that developing countries are increasingly needing expert advisers on health systems. We were wondering whether the best use is being made of NHS experts in assisting developing countries to strengthen their health systems.

Dr Chalkidou: As John said, there are certainly capacity issues in the NHS. The clinicians we work with take leave to come and work with us. They do not want to be paid for it because of the satisfaction in the sense that they are offering. But it is also very tricky for them to leave their NHS positions, as John did today in leaving his practice.

Dr Howard: Yes.

Dr Chalkidou: So I think there are issues around capacity, but they are not insurmountable. There are ways of supporting the NHS to do more. We have a fantastic brand overseas. With the momentum towards universal coverage, countries look to the UK as a model of an industrialised, successful country with a vibrant, home-grown pharmaceutical industry that has a fairly equitable, efficient and relatively good-quality system—I do not know if you have seen the latest Commonwealth Fund ranking of health care systems where we came first. Therefore, it can serve as a model. It is a fantastic reputation. We never sell ourselves. We get calls and e-mails from policymakers asking us to support them. So the demand is there. There are issues around capacity, but they can be addressed.

As John said, DFID could support us to become a bit more professional—although not professional consultants, because Johns Hopkins' offshoots have very competent and professional development consultants, and they are swift at bidding. We do not have that in the NHS, and perhaps we do not want to have that. However, DFID could support some basic infrastructure to be able to work to its rules. They are very important rules, of course, that it has to have to be accountable. Through that, it could also empower more clinicians, NHS managers and policymakers to share their experience.

Q79 Fiona Bruce: John talked about there needing to be a more structured, managed process. Would you agree that where there are existing schemes for volunteering oversees, they are fragmented and small scale—and that perhaps, through DFID, we need to further support initiatives like the Health Partnership Scheme?

Dr Chalkidou: It is a great initiative. We are getting supported through it. As I said, through NICE, we are using the skills of health care professionals, managers in the NHS, people at NICE, and also people at hospitals and primary care clinicians. So I think there is huge potential. There are caveats; there are bottlenecks; and there is limited supply. We are not McKinsey; we are not going to keep on hiring bright young people and sending them out there to do everything. The selling point of the NHS is precisely that: people want access to people who know how health care is delivered in the UK. So there are issues around capacity, but there is more that can be done.

Q80 Fiona Bruce: John, volunteering abroad obviously has an impact on the NHS if a doctor goes away for a year; do you think that on balance, the benefits outweigh the detriment?

Dr Howard: There is has been a lot of evidence compiled, not only by our volunteering statement—and there is a huge literature search that goes with that. The King's Fund also did a literature search, and the all-party parliamentary group looked at the evidence of how it helps UK health care workers, and the personal and professional development that that really supports and that they bring back to the UK. Of course, there are examples of good practice from overseas because, as Sir Nigel Crisp says, this is a two-way thing. We learn with and from each other. However, volunteering is not just within a single little package, as you know. It can be lots and lots of different things at different times in a person's career. In terms of medical, we have lots of undergraduate programmes, but they are largely unfocused. My own daughter has just been on an elective to Ghana, but it was self-directed stuff; it was not part of a managed programme. It could be so much more effective if it was part of a managed programme. They could actually gain more, and

locally they would gain more. That applies to junior, mid-career, end-career and post-career doctors.

Q81 Chair: Those are interesting points that you both made. First of all, listening to the debates in the media and in Parliament, you would not think that the NHS was the best system in the world. That is not what you hear, so that in itself is interesting. You were then saying that actually we have the capacity to use our NHS in ways that are beneficial to supporting developing countries and also in reinforcing the quality of our own health service, so it is kind of a win-win.

Dr Howard: It is. We have always said this, and there is evidence for this as well.

Q82 Chair: Michael?

Dr Johnson: Can I make a brief, unsolicited comment that is not specific to Global Fund? This is such an interesting and important topic you have raised around human resources for health and physician training. There is a study that was funded by the Gates Foundation about three or four years ago called the Sub-Saharan African Medical Schools Study—SAMSS. Nobody even knew at the time how many medical schools there were, and people thought that maybe there were 40 or 50. They have uncovered over 150. They characterised them according to strengths and weaknesses, and made several recommendations. Based on those recommendations, there is a large project that has been funded by the US PEPFAR programme called the Medical Education Partnership Initiative. It creates this institutional partnership. You were talking about these one-off exchanges, which are wonderful, but I think this idea of more structure is a really key idea. So there is some work going on, and I am happy to pass on the documents if that is helpful.

Fiona Bruce: Yes, you may provide any evidence. Please do send it.

Chair: Yes, that is very good. Sorry, Jeremy—you had a supplementary.

Q83 Jeremy Lefroy: Yes, thanks very much. I entirely agree with the Chairman that often we do down our NHS in public. I represent Stafford, a place that has been much in the news and where the health care has improved dramatically as a result of what has been going on over the last three or four years. I would absolutely emphasise that. I want to place that on the record, because often we do ourselves down too much on this. If other health systems had, if you like, the really difficult but necessary experience of what we have been through with the Francis report, we would find that they had dramatic improvements as well. It is just that we have been through that. It is largely the NHS that has been the reason for that, because we have a publicly funded and publicly owned health system. I just wanted to put that on the record.

I am going to ask a question about the future. This is particularly to Dr Howard. To some extent, I believe that we have had a golden age of the availability of clinicians to do this kind of work. I would ask you whether two things are going to have a detrimental effect. One is the increased specialisation in the medical world, where doctors are learning more and more about less and less, and are therefore perhaps less useful in the more generalised health system that they are going to come across in a developing country. The second thing is the impact of the working time directive in the UK, which means that—and this comes from the

Royal College of Surgeons among others—doctors are actually getting less training over the course of the number of years that they spend in it. I am wondering if this is going to have a long-term impact on the ability of those in our health service to be able a) to go and volunteer and b) to actually have the kinds of skills that people in the countries in which we work need.

Dr Howard: In terms of making the availability, that is a challenge because it is actually very difficult for people to be released from their work. There is no lack of desire to be able to take advantage of opportunities to volunteer. The skill sets that are needed can be found throughout the whole of the NHS. It is the availability that is the issue. For example, I can speak as GP: unless it is written into our partnership agreement that you would have a sabbatical, you are just doing it in your holidays like I do. So there is no chance. Many of our GPs in their early phases are salaried. It is not written into their contracts.

Clinical Commissioning Boards have taken over from PCTs. I may be wrong, but would doubt very much if there is a single CCG in the country that has volunteering in its business plan. They are too busy focusing on UK-centric stuff. As for the county-wide health and wellbeing boards, I am sure they are similarly occupied with keeping people out of hospital, and providing social and health care for their patients in the UK. I doubt very much that volunteering is on their agenda. There may be some honourable exceptions.

Q84 Jeremy Lefroy: Yes, sorry, I understand that. I fully get that. I am going to come on to that in my second question. I am talking about structural things that are happening in UK medical education and practice, and whether that is going to have a long-term impact.

Dr Howard: You will probably be aware that there is going to be a huge shift in where young doctors will work within the NHS. In their medical schools they are now told, "Half of you will be generalists. You will be GPs." Instead of saying, "Oh, you are going to be just a GP," they should say, "Look, our chairman of NICE is a GP." I am chair of the International Forum; I am a GP. GP is really the best speciality. So there is no lack of generalists. The two-year foundation programmes after qualifying as a doctor are generalist. The core skills training for most of the specialities is generalist. Then they reapply for more speciality training. So, in fact, when going up through the early years as undergraduates, then as new young doctors, then as middle-grade doctors, they are generalists. They may be generalists within their specialty, but they are generalists.

Later, as career doctors, they can bring an awful lot to those very fine specialities, but that is actually perhaps not what is needed in low-income, resource-poor countries. We can bring people over here for training, and one of the things that DFID can do is to help support the MTI programme, which is the two-year Medical Training Initiative programme over here for specific selected doctors for specialty training. However, we must not forget the end-of-career and post-career doctors. They have an awful lot of skill sets. They are not there to provide clinical care; they are there to provide support for local colleagues. There is plenty of enthusiasm. There is just not the structure and processes for that to work.

Q85 Chair: I just have a particular point. I know you want to come back, Jeremy. You are saying that people are just doing it in their holidays. We have also had situations such as the time of the Pakistan earthquake, when a lot of Pakistani doctors within the health service wanted to go and help. Some of them did, but they could not get unpaid leave; they could only take a holiday. Are you looking for DFID, perhaps through VSO, to work with the NHS to actually fund a programme where a legitimate part of aid support would be to fund sabbaticals for people in the NHS to go and do development work?

Dr Howard: Sure. That is one option. I think you have got to have a variety of different approaches. Certainly, the VSO are in partnership with a number of the Royal Colleges, as you are probably aware—with nursing, midwifery, obs & gynae, paediatrics, and general practice. They have good ongoing programmes, but they are small-scale. That can be scaled up. It is a good model; it can work. As you know, they are for longer placements, which tend to be more effective—unless it is for a particular skills, training or ongoing quality assurance visit—just because it is so tiring for the host country to have successions of very short-term things. It is very tiring. As you say, it is much better to have that look at that.

Q86 Jeremy Lefroy: I would give the example of something that I think DFID is in the process of putting together, which is the African Legal Support Facility. If I remember rightly, there is funding there for professionals to go and support countries in the negotiation of legal contracts. We felt that this was very important. What we are asking is whether DFID would support a similar type of fund that would support longer-term engagement by people who cannot afford to volunteer for extended periods of time.

Dr Howard: That is right. I guess another analogy might be the SaBRE for the Territorial Army, which supports health-care workers out of the NHS to have overseas placements through the Territorial Army. A similar sort of arrangement to be a backfill is perhaps required.

Q87 Sir Tony Cunningham: I will move on from the general question to specific questions, one for Kalipso and one for Michael. Kalipso, you have been critical of inefficient procurement and poor resource allocation by major multilaterals including the Global Fund. What should DFID do to ensure its money is spent more wisely by multilaterals?

Dr Chalkidou: I think the new funding model for the Global Fund is a great opportunity to inject some of the technical expertise that we have in this country—and in many other countries—into looking at the comparative clinical and cost-effectiveness of individual interventions, and helping the Global Fund implement the recommendations in both the market dynamics study and more recently the Centre for Global Development report that I have mentioned earlier.

There is potential in supporting the Global Fund and in introducing value-for-money evaluations when it looks at the top technologies it funds. One of the recommendations, in fact, was an opt-out function where a country would have to justify not going for the most cost-effective option. That is fine; I am not advocating for the most cost-effective option always being the only option. There are reasons why we should not go for that, as long as those reasons are made public and are discussed, as opposed to a situation where we do not know where the funding has gone.

I just want to say that I think the Global Fund has done a great job in improving on issues of corruption, and ensuring that the money goes where it says it goes. However, that does not necessarily address efficiency; that is not value for money. So, if I wanted to buy a Porsche, and you give me the money and I buy it because I said I would, but I could do my job with 10, 15 or 20 Volkswagen cars and I am not doing that because I do not have to, that is not corruption but there is still an opportunity cost there that needs to be addressed. The Global Fund could do that.

There is another thing it could do that DFID could support. The Open Government movement in this country is aimed at putting raw data on prescribing, for example, on the web. Bright young clinicians and start-ups are in fact looking at this data, analysing the data, putting it back in the public domain, and creating fantastic maps of variations in areas such as statin prescribing across the country. Why can the Global Fund not put data on what it is spending its money on, and the unit costs for its sub-groups around the world, on the web in a raw form to show where the money is going? Then people can start looking at it—not just in the wealthier countries but also in poorer countries. Where is their Government spending the Global Fund money? That is how accountability is driven: bottom-up. DFID can use this country's experience with open data to promote that model.

Q88 Sir Tony Cunningham: Michael, what does DFID do to audit how you spend its money?

Dr Johnson: As I mentioned, in the general sense, there are these multiple levels of engagement. Additionally, the DFID auditing apparatus—I do not recall its name—was recently involved with our Office of the Inspector General. They conducted a number of audits in-country, through paper examinations in Geneva and by interviewing staff. They have come out with a joint report. That report had a number of assurance recommendations, and we are in fact following that through the channel of our Inspector General, but DFID's auditors were keenly involved.

Q89 Sir Tony Cunningham: Can you provide the Committee with this information, please?

Dr Johnson: Sure, certainly—absolutely, yes.

Q90 Jeremy Lefroy: Can I direct this question particularly to Kalipso again? NICE International has got a growing international reputation and is getting funding from major independent donors. What do you think you need as an organisation from the UK Government or from DFID to help you scale up your work?

Dr Chalkidou: A few years back, I would say funding, but I am not going to say that now because we are feeling really confident—as I said, to a large extent thanks to DFID. As I said, its funding has helped us also leverage funds from large donors such as the Gates Foundation and the Rockefeller Foundation, and increasingly also from country Governments. So, I hope DFID continues to support us because this is truly important, not just in terms of the funding but also the reputation: the fact that we are backed by a very strong organisation with a good reputation globally.

My wish list includes something that is perhaps a bit difficult to achieve in any country: a bit more cross-Government co-ordination. We have worked at different points in time

with the Department of Health, with the MOD on multi-drug resistant TB in central Asian republics, with FCO offices in this country and overseas, with UKTI, and of course with DFID both in its country offices and in the headquarters here in London. The potential synergies of bringing the asks of these different groups together—instead of us having to interact with individual Departments separately—is huge, because there is huge overlap. DFID, being the big player with the knowhow in his field, has to have a leading role.

I have a couple more things. Firstly, when the UK Government's policymakers, the Secretaries of State or the Prime Minister go abroad, it is important that in addition to the very important initiatives that have been announced at different times in areas such as dementia and antimicrobial resistance, there is underpinning all this a focus on governance. This is the truly British good. I am Greek; I was born and raised in Greece and studied medicine in Greece, and I have been in this country for about 12 years. I can tell you that should not be ashamed of the fact you have got strong governance arrangements in this country that people are envious of. I am not saying that we can take this model and apply it anywhere. In Greece, for example, it would not work. However, I think that there are policymakers and citizens in these countries that look at the system and its governance arrangements and want to learn from it. I think that is important; it is a good British export and you should back it; you should support it, and you should be proud of it.

Finally, a last request is not to ask of us to make money. I do not want the NHS to spend money on this. The NHS is super-stretched. So, of course we are generating our own revenue, and DFID is supporting us. That is the way it should be. However, I think people are put off by this short-term, narrow, almost mercantilist approach to foreign policy, where basically we get approached by organisations in government that are asking, "Well, are you making money? How much money? What is your margin?" We need to be in it for the long term. We need to look at the reputational benefits to business as well of us being out there and working with the Chinese Government. If NICE can influence the way the Chinese Government decides which drugs it provides through its public health care system, that is a plus, I think, for our companies as well.

Q91 Chair: Yes, but you do charge for that service.

Dr Chalkidou: We do charge for that service. However, what I am saying is that you should not ask for us to charge McKinsey and Deloitte rates for that service. It will put off our clinicians if we say, "We are going to take you out and we are going to hire you out for £5,000 a day." That is not the right attitude. It is short-term and it is undermining. I think there are other ways that we can exert influence and support our businesses overseas.

Q92 Jeremy Lefroy: I would agree with that view entirely. You talk about governance. That is a great word, but what do you mean? What aspects of our governance of our health service?

Dr Chalkidou: Simple things. We are working with the new administration in India right now; my colleague Dr Cluzeau is in the audience. We are supported by DFID, who match the funds from the Government of India for its own stuff. We are looking to merge health insurance schemes to offer universal coverage for 1.2 billion to 1.3 billion people. It is on the agenda of the new Prime Minister of India. We are talking about things like conflicts

of interest. How do we record conflicts of interests at the committees that make decisions about what goes into the basic package? How do we manage conflicts of interest? How do we check that they are being truthful? These are things that we have been doing in this country.

We have been looking at simple things like forms or contractual arrangements. We have been doing tangible, simple things that are hugely important. I am not saying that things will happen if you have the legislation, or the circular or the form, but it is a necessary condition; if you do not ask the question about conflicts of interest of your committees making the decisions, then it is most likely that some people will have severe conflicts of interest. So we have been doing basic things. That is what governance is about.

It is necessary to consider what it means to engage the public through consultation. We have got 15 years' experience of working with patient groups and empowering them to "have their say but not their way", as Sir Michael Rawlins used to say. How do we do that? How do we engage with the public? What are public stakeholders? These are simple questions that fellow policymakers are asking us. We are not Africa experts; we are not India experts; we are health-care experts. That is why our partners in India and Africa want to work with us. The tide is turning and people are getting a bit fed up with development consultants. It is about what we know we do in this country, and about letting our colleagues in India adapt that to their own setting. It is not going to be the same, but let us build those relationships. That is what we are trying to do.

Q93 Jeremy Lefroy: I will just ask a final question. One of the big things at the moment in the health service in this country is on integration of health and social care within the health service. Indeed, I am putting forward a Private Members' Bill at the moment, one part of which aimed at helping integration of health services, and health and social care, through single identifiers across the system. Is this the kind of thing you are also working on in developing countries? Because clearly we are trying to get integration at a stage when our systems are relatively developed. It would be perhaps much easier if integration happened at a stage when systems are developing.

Dr Chalkidou: Precisely. That is really a very important point. All the time, we are talking about differences between rich and poor countries. However, there are things that poorer systems can do better than we can, because we have got a history that is perhaps an obstacle to change as opposed to facilitating change. Integration is one those things. With funding from the British Embassy in Beijing, we are working with the Ministry of Health of China in rural provinces in central and western China, looking at integration between different tiers of care. In fact, we are working with the Director for Enhancing the Quality of Life for People with Long-Term Conditions at NHS England, Dr McShane. We have been in touch with him and he kindly agreed to help us. That is the sort of exchange that I think we should be looking at. We can even learn from what our Chinese partners achieve. They have huge scale and obstacles compared with our NHS.

Q94 Chair: Well, thank you all. Sorry—Michael?

Dr Johnson: Can I just make two quick interventions if I may? Sorry. Kalipso talked accurately earlier about the great variability in the cost of commodities. However, I would like to just set the record straight: there are great variabilities in cost, but I would not want

to portray the idea that the Global Fund just accepts and pays those. Every country team in the Global Fund has on it a procurement expert with linkages to the central procurement staff in the Global Fund, and every one has a finance officer on it. Budgets are combed specifically for outliers and for what you might say are ridiculous costs—things that we should not be paying.

Dr Chalkidou: If you could put this data in the public domain, I think that would be hugely helpful.

Dr Johnson: That is fine. We are very happy to do that to the extent that we can—because some of it is country-specific and proprietary information. However, we are happy to do that. Also, I do not know if within your remarks there would be an offer or an opportunity for someone from DFID to come in and work with us on this, but I just want to take that as leverage to really emphasise as a closing remark that we are an organisation of partnerships. We welcome partnerships at any level, especially from DFID.

I mentioned the board and the Strategy, Investment and Impact Committee that you are represented on. We are taking people as secondments and loans into the secretariat for various technical partnership areas from the US Government, the UK Government, the French Government and the German Government. We welcome the opportunity to work with DFID at that level. Also, first and foremost, at the country level DFID field officers can be, should be and in many cases are on the CCMs involved in the country dialogue in the new funding model. That is at the technical level and it also goes up to the political level. The UK ambassadors have a major role to play to help us when a local ministry is making decisions that we do not feel are strong. We do not have the leverage to say, "Do this, do that." You and other donor Governments do, so we want your involvement at all these levels. So thank you.

Chair: First of all, as Kalipso said, we accept that the Global Fund, GAVI and everything else were set up to do specific things that they have done extremely well. What we are hoping for as the outcome is that the legacy, nevertheless, is that they have not only delivered those results but have also helped to create stronger permanent systems. At some point or other, those funds will diminish because the prime objectives have been achieved. We want to know there is a legacy that is left behind, which is the existence of stronger health systems than would have happened without their engagement. I guess that the bilateral partners can help with that.

Q95 Jeremy Lefroy: I just wanted to look at almost the other end of the lens, specifically for the Global Fund or GAVI. We found one specific example in Liberia, where we were recently. We saw that the health system had an enormous amount of funding from the US Government, and a substantial proportion of that was on HIV/AIDS. I fully understand that. However, to some extent, it was a distortion of the whole health funding. It looked as though Liberia was spending a considerable amount, from its own resources or from donor resources. However, a large amount was very much focused on HIV/AIDS. As I say, I have no problem with that in principle, but it seemed that in this case it was not contributing to the strengthening of the health system. It was an enormous amount of money that could have, spread more widely, really strengthened the health system.

I wonder what role the Global Fund, GAVI and other international organisations can have in working with other major countries that are supporting health, such as the US, and

saying, "Look, you are giving this amount of money. Can we not suggest it is dealt with in a slightly different way? Because clearly there are other great needs, and health systems strengthening is absolutely vital." Clearly, it is more difficult for us as an individual country to challenge what other aid agencies are doing. They are very protective of that, and I understand it. However, global institutions of which we are a major part surely can have that kind of conversation. I wonder if that does go on. You may disagree with me; you may think that what is happening is absolutely fine. However, I wondered if there is a channel through those global organisations—obviously the WHO is the major one—and even through your organisation to say, "Look, perhaps you could look at spending the money in a slightly different way locally?"

Dr Johnson: It is a very fair point and I think there is a spectrum. I have been to places—of which there were more years ago than there are now, I hope—where there is a clinic that is funded for AIDS and is looking great, and one next door that is not. I have seen that and I think we are evolving past that. The place where that can best happen is at the country level. The Global Fund is not a technical agency; we are a partnership-funding organisation. So we welcome and encourage that kind of debate to go on at the country level with the US PEPFAR programme and DFID round the table. Most importantly, we would hope and encourage the host country Government to be at the centre of that table, so that these resources can be more rationally and intentionally distributed. We are open to that.

I will not go into too much detail as I know we are near the end time-wise, but in the new funding model there is a notional split between the three diseases and HSS that is based on history. However, in no way do we impose that on any individual country. Any country can come in and say, "In our situation we want to shift the proportions in a certain way." So, there is flexibility for that. Again, it gets back to this point that if you are making recommendations to DFID, those recommendations in my mind could be to be involved early and vigorously in these country dialogues and in these discussions that happen where all the donors are supposed to put their cards on the table.

Q96 Chair: I guess what you are saying is that there are particular constraints on the US funding model that do not necessarily apply to you unless you are working in partnership with the Americans. In other cases, you can do it according to what other partners want. The point that you are making is that you have the flexibility to do it in different ways. The particular point that Jeremy was making is that in Liberia the American system of funding is inhibited by congressional rules. There are lots of things that everybody else would like them to do that they either cannot or will not do. That does not apply to you.

Dr Johnson: Correct. Our body of controls, if you will, is our board.

Dr Howard: Chairman, my question to you was: why do DFID commission resources for education and training from outside of the UK when actually the brand, if you like, of Royal Colleges is seen as a gold standard throughout the world? It is what everybody wants. They want Royal College-standard quality in their education, training and exams, and yet we never see any of the requests coming to us. Can I give you that question?

Q97 Chair: That is a question we can ask of our Minister who is coming along next, it seems to me. We will make a note of that and redirect that question to her. It is a fair

question. It arose out of some of the discussions about the priorities within the NHS. The NHS is there to deliver UK health care; how do you work it so that it does not divert attention away, or adds value. So we have partly looked at that discussion, but I think we would want to ask the Minister about your specific point in terms of commissioning. It was a fair point.

You said you would give us some additional information already, and we would appreciate that. However, if you also have any reflections after this of things you would like to follow up, I hope you will feel free to add it in a note or to contact our adviser. It does not stop just because the evidence is finished; if you have got any further thoughts or further information, please feel free to deliver it to us. So thank you very much indeed.

Examination of Witnesses

Witnesses: **Lynne Featherstone MP**, Parliamentary Under-Secretary of State, Department for International Development, **Jane Edmondson**, Head of Human Development Department, DFID, and **Angela Spilsbury**, Senior Health Adviser based in Ethiopia, DFID, gave evidence.

Q98 Chair: We will make a start. We are just waiting for Jeremy and he will be back in a minute. Thank you, Minister, for coming in. I am sorry that we have taken a bit longer on the first evidence session, but we obviously found some interesting issues to explore. I wonder if you could just introduce the team for our records.

Lynne Featherstone: Okay. I will let them introduce themselves. Angela?

Angela Spilsbury: Thank you. Angela Spilsbury, Senior Health Adviser from DFID Ethiopia.

Jane Edmondson: I am Jane Edmondson, head of the Human Development Department in the Policy division.

Q99 Chair: Okay, well, thank you very much. The issue that has really emerged is the conflict between health systems strengthening and delivering outcomes—the difference between doing that and the global funds. Dr David Evans from the WHO felt that strengthening systems was becoming much more important, and that we should be moving away from the focus on quick wins and measurable outcomes. He feels that that has run its course. Do you accept that that is a reasonable analysis, and has it had an impact on the way DFID approaches its health delivery policy?

Lynne Featherstone: This is a really interesting issue as time has moved forward. When development aid started and was going into countries with no health systems, or that were so low on the capacity scale there was nothing there, it would have been incomprehensible to have waited for a health system before you went in and targeted vaccinations, or maternal mortality or those sorts of things. In terms of a country's readiness for a health system, I think there is an issue around timing. However, obviously as we have gone on and as these amazing global funds have done such brilliant work, there is a change. DFID

itself has always been an advocate for health systems strengthening because there is no sustainability around the vertical approach to disease.

One of the things DFID is very advised of and acts on is supporting national systems, building health systems, strengthening health systems, but also trying to influence those who run the global funds to do likewise, so that you use the opportunity of a vertical operation to actually build some resilience and strength around its capability. If you take those countries where there are not really recognisable health systems at all, if you have maternal birth clinics of some sort, then it would be obvious, and DFID encourages this cross-fertilisation, to build a system around that so that when someone comes in to have a baby, they are recognised in terms of bringing their babies in for vaccination and so on. There are a number of ways of strengthening health systems. These are different in different countries. Ultimately, you want everyone to have a health system that is as good as the National Health Service, but they are starting from very different bases and they started with different people being willing to do different parts of that whole agenda.

Q100 Chair: Just on that point, you will not be surprised to hear this because it is not the only context in which it has been said, but NICE International, who we have just been talking to, said that a fixation on achieving short-term measurable outcomes is "perhaps the biggest obstacle to DFID fulfilling its role in systems strengthening". Do you recognise that tension?

Lynne Featherstone: No, I do not agree with that. I know it is a criticism that is often levelled because of some of the ways we measure health outcomes.

Q101 Chair: Well, the MDGs encourage you to do that as well.

Lynne Featherstone: Yes, the MDGs as well. If you looked globally at, say, the DFID budget, part of our input goes towards the results in the MDGs—which are driven by results and outcome-focused. I very much agree with that. I also think it is a very good way of measuring health systems when you have put it back. However, half of our money does not go on those results and is not narrowly focused, and actually is there to build the health systems. So, while I accept that we do have results and we do measure by outcomes, I would also say that where you have good outcomes you also tend to find good health systems. We are not so narrowly focused; we measure outcomes because in the end that is what we are trying to achieve, but in the individual programmes we track indicators of health system performance such as rates of skilled birth attendants, for example. So I do not think this is an absolute criticism.

Q102 Chair: Just to summarise, the first strand of evidence we had was that the perception was that in its bilateral programmes DFID was definitely good at building health systems. That reinforces what you were saying. The question was whether or not the engagement with the multilateral organisations was as focused on delivering that. You do not need to answer that now, as I think our other questions will probably deliver that.

Lynne Featherstone: Will we come on to that? Okay.

Q103 Fabian Hamilton: This Committee, Minister, has heard praise for DFID's continued focus on systems in its bilateral programmes. I wondered how you could ensure

that those systems are prioritised in countries where DFID does not have a bilateral programme?

Lynne Featherstone: Where we do not have a bilateral programme, that is exactly why we use the multilaterals, because we can reach countries that we have no ability to reach otherwise. For example, there are 53 countries eligible for GAVI, and obviously the Global Fund works in over 140 countries. We use our position on the boards of those global funds to push the health systems strengthening agenda. However, we also do other things in countries where we do not have bilateral programmes, for example, global public good. We have great emphasis on research, evaluation, product development and market shaping. They are available to all countries. If you take something like the Global Fund, these huge funds have an ability to drive down the price of commodities. The price of antiretrovirals for HIV has dropped by 99%.

Q104 Fabian Hamilton: Sorry, can you just say that again? Did you say 99%?

Lynne Featherstone: In low-income countries, yes.

Q105 Fabian Hamilton: So it is now 1% of what it was—how long ago?

Lynne Featherstone: I would have to come back to you with the date.

Chair: It is about five years, I suppose.

Lynne Featherstone: Is it five years? It is a phenomenon. However, it is not just about the fact that it has driven down the price; it is that when the price is low it enables a country to develop a health system, because the drugs become affordable by the country's Government in a way that they were not before. We would never have got to that without the global funds being able to push down the price of commodities.

Q106 Chair: I am interested in where DFID's health systems strengthening programme has been the most and the least successful. I wonder if you could tell us a bit about what lessons have been learnt where we have been involved in those programmes—especially the least successful ones.

Lynne Featherstone: I am going to use a successful one first. One example would be DFID's support for health workers' salaries in Sierra Leone. I know the Committee has just come back from there. That was evaluated in 2012, and the recommendations were then used to inform future support. So that is a successful intervention. I would have to turn to Angela or Jane to give me an unsuccessful one.

It seems that we cannot think of an unsuccessful example.

Q107 Fabian Hamilton: That is good that you are not able to think of one. That is excellent news.

Lynne Featherstone: There are probably more and less, because we work in a direction; there is no absolute on these and they are all different. We do different things in different countries.

Q108 Fabian Hamilton: What are the lessons you have learned from the successful ones, then, about how to make them more successful—or why they are successful?

Lynne Featherstone: We have increased our focus on the evaluation of our health systems strengthening. When they are analysed and evaluated, that enables us to improve policy and programming effectiveness. I would say that what we have learned is the evaluation. I would have to send the Committee actual examples. I think I do have some in the back. Do you want me to scrabble through my papers?

Chair: No, no, it is okay. No, you can send us some examples.

Lynne Featherstone: They are quite complex and involved, but we do evaluate our programmes. That is how we learn in terms of our future programming and policy each time.

Q109 Jeremy Lefroy: Good morning, Minister. The additional commitments by DFID to the Global Fund and GAVI have been widely welcomed. When the increase in funding was made, was there any emphasis by DFID on health systems strengthening as an important component that both the Global Fund and GAVI needed to concentrate on? If so, perhaps you could give us some details.

Lynne Featherstone: Yes. I think there is a very important role for DFID in terms of our contribution to the global funds, both GAVI and GFATM, to add to their health systems. A focus on health systems strengthening really should run through all work to improve health outcomes. In terms of GAVI, the UK led the call for GAVI to prioritise health systems strengthening and was instrumental in GAVI's HSS spending target.

As I said, we use our board and committee positions to push this all of the time, and we very much use funding as leverage in terms of the direction in which we think they should be going. We have no hesitation in putting that forward, because simply financing vaccines is not enough. We see in-country that it is just not enough. Obviously, as I said, in a country where there is nothing else, you are not going to wait for a health system to go and do vaccinations. Nevertheless, now we have these massive global organisations, strong systems are needed to get the vaccinations to the children who need them.

In a country that has a UK bilateral programme and is a recipient of GAVI, we also push them to be complementary to what we are doing in-country, each working to comparative advantage. In countries such as Malawi, Ethiopia and Uganda, we would fund core health systems support including human resources for health, drugs and equipment. GAVI finances the vaccine cost and the grants to strengthen the immunisation system. So we work together with the global funds in the country.

In terms of the Global Fund, we have encouraged—and will encourage—GFATM to continue to invest in health systems strengthening. They have moved from dedicated health systems strengthening grants to actually ensuring that the grants for each of the diseases have a strong health systems strengthening focus. We think that they strengthen their health systems in three main ways. Targeted health systems strengthening funding has helped to directly fund issues such as data systems, supply chain systems and human resources for health. They are encouraging the use of national systems for data and other requirements, thereby strengthening these systems by using the national systems and not building parallel systems—which just ends in madness, to be honest. Indirectly, they are having a huge positive impact on health systems by funding successful prevention and

treatment programmes against the three diseases. Fewer health staff are actually dying of those diseases, which has also been an issue. Their patient load has dropped dramatically. So, yes, we do push them. That is the short answer.

Q110 Jeremy Lefroy: We seem to be getting a slight contradiction in views. We have some people telling us that DFID has reduced—and some would say almost abandoned—its thought leadership on health systems strengthening. They give examples such as DFID declining to send a Minister to the Third Global Forum on Human Resources for Health, and lagging in the implementation of the International Health Partnership Plus principles. However, on the other hand, we are seeing very substantial DFID leadership in these very important programmes of the Global Fund and GAVI—and also, as we have seen on the ground, to be quite frank, substantial leadership where we have bilateral offices. So I wonder where you think this is coming from, and whether there is something more that DFID could do to allay the fears of some people that we are ceding thought leadership in this area—if indeed we are.

Lynne Featherstone: Thank you for giving me the opportunity to say publicly that we are committed to health systems strengthening. We are certainly regarded as a world leader in terms of our bilateral programming. In everything else we work with others to push that agenda. However, it has to be said that institutions like the World Bank are incredibly strong in terms of strengthening health systems. We do not have to lead on absolutely everything and be at absolutely everything. It is simply not possible. However, I just want to give the assurance that even if we did not send a Minister to that particular meeting, it does not mean that we are not committed to health systems strengthening; we are.

However, I am very happy for there to be other world leaders on these things as well, so long as we support, encourage and push, and grow that agenda, and make sure that the money we have is used to that end. That is a good structure on which to be based. So I would love to be world leader on everything, but I think it is not possible for DFID to do absolutely everything and to be at absolutely everything. However, I am very pleased to have the opportunity to put on the record that it is one of our modus operandi.

Q111 Jeremy Lefroy: Thanks for that. We heard evidence in our first evidence session about gap filling, in which organisations focus on what they do well. I wonder, Minister, if you think that we have a comparative advantage in health systems strengthening, and therefore that this is something that we actually should take the leadership on—although clearly in certain ways we are already taking this leadership—because it is something where we have both national experience and a long history through our overseas development programmes.

Lynne Featherstone: I think that to an extent it comes naturally, directed by the context in which we are working in-country. As you know, our health advisers are very experienced at working with Governments, and generally know the mapping that goes on in a country in terms of that. We are generally working and aware of map gaps. We have stepped into gaps ourselves—for example, where we have seen a gap, say, in the Global Fund in terms of malaria in-country, we will step into that gap. We also have to learn how to step out of the gaps. There is quite a balancing act going on; where we have the comparative advantage and where we know, and where we are able, then we should not hesitate to.

However, there was a very generous pledge this year to the Global Fund, and it is also part of the way of things that there are some things that they are better at, and we just need to make sure that we are complementary and working with them. I do not think it matters who does it, so long as it is done.

Q112 Jeremy Lefroy: I am sure we would agree with that. The concern that I have is that where we do have bilateral programmes, we normally have health advisers—and pretty strong ones. Certainly, the ones that we have seen are strong. However, we only have bilateral programmes in 28 countries. We are, through multilateral organisations, operating in far more than that. I wonder how DFID can be sure that in those countries where we are not operating bilaterally, but where nevertheless through multilateral partners we have a very significant programme, we are able to ensure that there is that same level of engagement by somebody else. I totally agree with you; it is not up to the UK to lead in every country and in every respect. We cannot possibly do that, nor would it be right for us to do so. However, it does seem to me that, where we are contributing large amounts of money through multilateral organisations in an area in which we are recognised to have expertise and yet we do not have that expertise on the ground, we may be missing something. How would you respond to that?

Lynne Featherstone: I will let my officials come in on this one. However, that is why we sit on the boards of the multilateral funds. We are not going to have every country coming to us.

Q113 Jeremy Lefroy: Yes. It is going to be very difficult for somebody sitting on a board, however much they do the work, to know what is going on on the ground with what may be very substantial programmes in health where we have no input.

Angela Spilsbury: One way that we have been working to promote health systems strengthening through others is with the International Health Partnership. This was a DFID-spearheaded initiative that was set up in 2009-10. Within that, we created an agreement amongst the main partners in international health to really pioneer and lead on health systems strengthening. We put the WHO and the World Bank in the driving seat for that. Through that partnership they are working with Governments to make sure that countries, and donors working in those countries, are actually working towards supporting a systems approach—and supporting what the Government and the host country want to be achieved. So, even though we are not necessarily in those countries, we have set up the global governance structure that will enable other partners to lead on health systems strengthening and further the agenda that we have.

Lynne Featherstone: The other thing that is happening at the moment is that, with our development aid tracker, we are in the process now of geocoding what central funds and multilaterals do in each country. So it is not perfect, but I do not think we would ever say that we could absolutely identify everything going on in every country and every gap. However, there is a global way of tracking, if that is what you were asking.

Q114 Chair: I can follow that up. I do not dispute at all that that is what DFID is trying to do. We know it is doing it bilaterally, and you were telling us how you are influencing multilaterals. However, there has been a suggestion, first of all, that other donors take a different view, and that actually health systems strengthening is less important to them

than delivering measurable outcomes. In particular, the Gates Foundation are very keen on delivering specific outcomes. They are now the WHO's biggest donor. So how can you ensure that, in that context, you are not driven by other donors' priorities? For example, if Gates is the biggest donor for the WHO, how can you be sure that DFID's priorities and the WHO's are going to be in the same direction?

Lynne Featherstone: Well, we fight.

Q115 Chair: Can you give us examples of where you have actually had to assert that?

Lynne Featherstone: The Bill and Melinda Gates Foundation, as you say, had a reputation for focusing mainly on developing new technologies to address problems with the health of the poor—most notably and most famously in terms of new vaccines and polio, for example. However, it is not correct to argue that working with the Gates Foundation, for example, reduces our focus on health systems strengthening. I would argue that it is the other way round: by working with the Bill and Melinda Gates Foundation, we have actually influenced them to understand that simply delivering a vaccine is not the answer and that you have to strengthen health systems if they are going to be sustaining.

I will give a couple of examples of what we do. We are working jointly with them on a programme in Kenya, Ghana and Nigeria that focuses on improving the quality of care delivered by private providers. We are reducing barriers to access to care by supporting countries' health financing systems, and supporting Governments to improve their stewardship of the whole health system. So, by working with us, they are now broadening the scope of their operation, whereas I think that when they started they were definitely focused in a very vertical manner, and would use that influence on the WHO for the same. I think there is a general acceptance across the board that that is no longer enough—that simply delivering a vertical system that is unsustainable and does not build a domestic strength in that capacity is not adequate. You are seeing quite a shift across to that view.

We are jointly funding NICE International with them, to help countries make fairer, more transparent and more evidence-based decisions about how to spend money on health. Health financing is another big area. They are a very important donor to GAVI, the Global Fund and the Global Polio Eradication Initiative. We work very closely with them on strategic engagement and how to strengthen health systems around that. We do not have control over them.

Q116 Chair: You are saying that you push them more in your direction than the other way round. That is what you are essentially saying.

Lynne Featherstone: Yes. I would think that they have come from that in a very strong way, but they are now moving towards broadening their scope.

Q117 Fiona Bruce: As I understand it, DFID have been working on health systems strengthening for some decades, yet you are still unable to tell us how much money you are spending on this. We have also been told in evidence that there is an absence of measurable targets for health systems work, and a lack of systems strengthening indicators. Do you think this is satisfactory after all these years, and what is going to be done about it?

Lynne Featherstone: No, it is not. It is probably a relatively fair target for a recommendation from this Committee. I am sure we will see it there. As I say, I think that we get a pretty good idea of health systems from the way that we measure outcomes, because clearly it measures the actual improvements in health, and you do not get them unless there is a functioning health system—unless they are very specific targets.

As I said, we are doing some work with ARIES, which is our computer system. Our country advisers are now working more closely in terms of what is happening in each country, but we do not have a specific target on strengthening health systems. We have one, but I do not know what page it is on, sorry. I cannot find it at the moment. The argument is that we do perhaps need to get a better and clearer idea, but we have always believed that the outcomes were more important.

I was trying to think what that might look like and I was thinking, "Well, how would you do it? Would it be the number of trained health workers, the number of doctors or the numbers of clinics? Would those be targets?" However, I am slightly worried that, if we went that way, that would become the focus, rather than the outcomes from the health systems that we were delivering. So I think it is really quite complicated to ensure that those things do not become an object in themselves, and that we do not lose sight of the health outcomes because we are being encouraged to have particular health systems strengthening targets. I would simply ask that perhaps when the Committee advises us, they also consider how to avoid falling into the trap of that becoming the object, rather than an outcome.

Q118 Chair: In Sierra Leone and Liberia, the respective Governments fed back to us that access to health facilities in terms of distance was one criterion. They also recognised in Sierra Leone that they had done the access, but they had not done the quality. So they then had to import some quality standards. But at least they were beginning to think about measuring. Presumably, by discussion, you could come up with indicators that would give you a better focus than you have now.

Lynne Featherstone: Yes. I will give you a couple of examples where we are doing it. If you take Ethiopia, we are providing sector-wide health support to the Government through a pooled fund managed by the Ministry of Health—where I was yesterday with Angela—plus contributing to block grants to districts that are earmarked for basic service provision. So an example of the programme would be support for the Ethiopian health sector development programme through the Ministry of Health. We can send you these examples and charts, but I will just do Ethiopia.

Chair: That would be helpful, thank you.

Lynne Featherstone: The outcome "improved access and quality of health service" indicators include: contraceptive prevalence, skilled birth attendants, percentage of children under five sleeping under a bed net, immunisation coverage, and outpatient attendance per capita. Gaps between the richest and poorest socio-economic quintiles are also measured for some of these, and so on and so forth.

Angela Spilsbury: Can I just add to that? We also do actually track health systems strengthening indicators like ratios of nurses and doctors to population, the percentage of facilities that are able to provide emergency obstetric care for 24 hours a day, and also the

availability of drugs. So there are some specific systems indicators that we track at the output level. However, at the outcome impact level, we are looking at things like maternal death and infant death, which are the outcome of whether or not a health system is there and effective.

Lynne Featherstone: We will send you some more examples.

Chair: That would be helpful.

Lynne Featherstone: It is emerging thinking. It is about asking, "How do we get these two things to both be beneficial, rather than contraindicators?" Jane wanted to come in on universal health coverage.

Jane Edmondson: You asked what we do about it, and I think there is a recognition that, while we do measure them in individual programmes and things, there is not a globally recognised set of indicators. So we are working, and we are supporting some work by the WHO and the World Bank to develop a set of indicators, with the idea that we could agree a set of indicators that could be used in post-2015 goals.

Lynne Featherstone: I was going to go on to 2015. Our position in terms of health is that the goals in the post-2015 framework should be outcome-based—because, ultimately, what we are trying to do by 2030 is help people live longer, healthier lives. Others have been arguing strongly for universal health coverage to be the goal itself. We have been very consistent in supporting that. We are finding our way through, but those new MDGs will be very powerful, in terms of where we go as well.

Q119 Fiona Bruce: So you will have those and also, you say, you are working on health strengthening indicators. Obviously, a lot of money has been put into multinationals, as Ms Spilsbury said, on this very issue. As a Committee, whilst we have heard praise of DFID's system focus on the bilateral funding, we have actually heard some quite concerning evidence about multilateral funding. I really would like to drill down and ask you for some examples of where you have had sufficient systems focus on projects that have already occurred with regard to multinational funding for health systems strengthening. Can you give us some examples that will give us confidence that DFID is holding these multinationals to account?

Lynne Featherstone: In terms of specific examples, I would have to go back to what we have done and what our interventions have been in terms of multilaterals. We have constant dialogue with them. As I said, we operate not just at board level but committee level. In terms of specific examples of an actual delivery in-country, I would have to go and find them and provide them.

Q120 Fiona Bruce: That would be appreciated. Thank you very much. Turning to the Global Fund, we have had some evidence on this saying that "spending leaves significant opportunities for efficiencies". You mentioned, for example, bed nets. We have had some evidence that better-informed procurement of bed nets could save the fund $340 million over the next five years. A previous witness here today said that the new money for the Global Fund is a great opportunity to inject expertise and new evaluation opportunities—for example, that raw data should be put onto the web, so that we can really scrutinise what

money is spent globally by the Global Fund. Could you comment on how we can ensure that, when we audit organisations like the Global Fund, this is done effectively?

Chair: This was witness evidence from NICE International.

Fiona Bruce: Yes.

Lynne Featherstone: DFID's internal audit team recently conducted an audit of the Global Funds fiduciary assurance mechanisms. We will be working closely with the Global Fund, particularly over the next six months, to strengthen fiduciary assurance and to implement the recommendations of the audit.

In terms of what they actually deliver, aside from the formal opportunities of being on the board or the committee to monitor funds and flows, the staff managing our investments and relationships with the global funds have continual and ongoing dialogues with the secretariats. They consult regularly with our country offices—who, as you say, have context-specific knowledge—to ensure that our funds are being spent appropriately and that the global funds are effectively militating against the fiduciary risks.

You are talking more about value for money, in terms of whether we drove that price down in that country. We take an overview on that. Indeed, part of the benefit is that, when we did the multilateral aid review, these funds did extremely well in terms of expenditure. Having evaluated them and updated our evaluation, there will be another one next year. That is really how we examine what they are doing and where they are doing it, and if we think that is delivering our money well. We do not do that on a drill-down all the time. That would take an awful lot of resources, when we have evaluated any particular multilateral fund as being worthy of receiving such a large amount of our money. In a sense, after assessing them as the right organisation to deliver a particular thing, we then periodically examine that they are still the right organisation—that they have delivered and that we are getting value for money.

Q121 Fiona Bruce: One of the ways that we could all better hold them to account is with greater transparency. Would DFID use its influence on the Global Fund board to encourage them to be more transparent?

Lynne Featherstone: Yes.

Fiona Bruce: Did you want to add something, Ms Spilsbury?

Angela Spilsbury: From a country point of view, the majority of DFID health advisers are involved in supporting the countries to write the proposals for the Global Fund. That is often a great opportunity for us to really start drilling down into some of the detail—which we would not necessarily do from the centre but we can do at country level—to see why certain decisions have been made around commodities and which commodities to procure. That is where we can have a much more detailed analysis on the value-for-money aspects, and have those debates with the country.

Q122 Jeremy Lefroy: I perhaps should have posed this question to the previous panel. We visited the bed net factory in Arusha, not with IDC but with the all-party parliamentary group on malaria and neglected tropical diseases. The factory is very large,

and DFID has been very much supportive of it. Indeed, DFID has got a sign on the outside of the factory. One thing we were told was a problem for procurement was the way in which the Global Fund procured on a free-on-board basis. This meant that even though a huge factory based in East Africa was able to deliver for a cheaper price to other countries in the region, because their free-on-board cost was perhaps slightly higher than from other factories across the world, it meant that they could not necessarily be competitive. To the Members of Parliament who were there, it seemed to be a bit of an anomaly. Have you had any indication that the Global Fund is looking at things like that? It seemed to us to make little sense. Local production was able to deliver cheaper, but was not competitive when compared with its actual free on-board or free-out-of-factory costs. I do not necessarily expect you to have an answer to that straight away, but it would be very good to put that on the record, and see if they have come back on that. That was a specific example that all three Members of Parliament on the trip were exercised by, in terms of strange procurement. The company was possibly very much talking in its own commercial interest, but it did seem to us to make sense.

As you know, there are now quite a lot of mosquitoes resistant to straight insecticide-treated bed nets, which are done just with pyrethrum. Companies have developed a combination of insecticides in order to better protect those who are sleeping under the bed nets. Again, there was a concern that, because people were looking purely at cost and not at effectiveness—clearly, those combination insecticides cost a little bit more than the single insecticides—we were going to end up with less effective protection offered by the bed nets. Again, I do not expect an answer on this, but it would be good to have an answer back, either from DFID or from the Global Fund, as to whether these issues are being addressed at the moment or have already been addressed. That would make a significant difference in value for money and procurement.

Lynne Featherstone: You raise a good point. I do not know the answer off the top of my head. I do not know if Jane wants to come in on this, but it is certainly worth us going back to the Global Fund and finding the answer to your question.

Jane Edmondson: It is a well-recognised challenge. There is a balance between reaching the most people with the cheapest product and strong procurement, and making sure that we grow markets that can compete. Clearly, that has much broader benefit.

There are a number of ways in which we support that kind of work, including working with the WHO and with other organisations on market-shaping strategies. This is about thinking ahead: how can we grow markets for the future that will be able to compete? The WHO does a lot of work on this, in its schemes for accrediting companies. We have provided support to pharmaceutical companies, for example, in developing countries to get the WHO accreditation, so that they can start to compete in procurement exercises.

We are ensuring that we keep a strong pipeline of new products coming in, as there is the same resistance on the drugs side. A lot of our research and product development is around that. The current generation of insecticide-treated nets, when they first came out, were extremely expensive. The cost of those has driven down. Making sure that we are planning ahead and investing, to keep that supply chain coming, is important.

Q123 Fabian Hamilton: Minister, to what extent is continued DFID funding for multilaterals dependent upon them exercising a systems strengthening focus? Would you

consider withholding funds if those systems were not being strengthened through the money that we give to multilaterals?

Lynne Featherstone: Well, let us hope that situation does not arise.

Fabian Hamilton: Absolutely, but would you consider it?

Lynne Featherstone: We always consider. For example, with the Global Partnership for Education, I recently was looking very strongly at their words on disability and inclusive education, in terms of the relationship to how much I was prepared to pledge. I was satisfied.

Q124 Fabian Hamilton: That is good. Can you provide any specific examples of DFID using its membership of the Global Fund or GAVI to successfully promote a systems agenda? If you have not got them available, do not worry; you can let us know later.

Lynne Featherstone: One example is GAVI health strengthening system grants, which we have encouraged them to have. They have helped increase the pneumonia vaccine coverage from below 5% in low-income countries in 2000 to above 95% in 2013. We have used our influence, at board and committee-level, to ensure that GAVI enhances its focus on improving coverage and equity rates; strengthens vaccine supply chains for investments, which improve immunisation outcomes and mitigate the fiduciary risk; improves the sustainability of national immunisation programmes; and, further, shapes the vaccines market, including securing appropriate pricing for countries that graduate off of GAVI.

At this year's GAVI replenishment launch, the UK company GlaxoSmithKline committed to supporting developing countries that have growing economies by offering a five-year freeze on vaccine prices for countries that gravitate away from vaccines. That is slightly off topic.

Q125 Fabian Hamilton: They are all really important examples that obviously help the health systems.

Lynne Featherstone: They are the ways that those organisations help health systems.

Q126 Fabian Hamilton: But are you satisfied that they actually contribute to the strengthening of those health systems?

Lynne Featherstone: Yes, I am. Do you want me to go through the Global Fund as well?

Fabian Hamilton: No, that is fine.

Lynne Featherstone: I am happy that it does. It is not health systems strengthening in the sense that perhaps DFID would do it in-country or working with country Governments, but it does work with those kinds of systems to strengthen the parts that are appropriate to its central focus. They do not do a separate job on health strengthening.

Q127 Fabian Hamilton: This inquiry is about health systems strengthening. Our concern is that the large amount of money that DFID gives, very justifiably, to multilateral

agencies such as GAVI and the Global Fund is actually contributing towards those health systems being strengthened.

Lynne Featherstone: I am happy that it is contributing towards it.

Q128 Fabian Hamilton: Especially in the countries where we have no bilateral programme.

Lynne Featherstone: Especially where we do not have any programmes.

Q129 Chair: Do GAVI and the Global Fund talk to each other about how their activities can be synergistic?

Lynne Featherstone: I am sure they talk to each other all the time.

Q130 Chair: I know, but for this particular purpose?

Lynne Featherstone: On that specific issue.

Chair: Yes.

Angela Spilsbury: There is one example from Ethiopia that illustrates this nicely. In Ethiopia, DFID was instrumental in setting up something called the MDG pot, which was a pooled donor fund, managed by the Ministry of Health, to support health system strengthening. This was started in 2008 with us and the Italians. Now, in 2014, we have 13 different donors that contribute to that pot, including GAVI, who give un-earmarked health systems strengthening money for the strengthening of health systems—not just for immunisation. It is a broad range, from training health workers, to building health centres, to buying medicines, vaccines and equipment that a country needs to run a proper health system. Now, we have just had announced that the Global Fund will also contribute un-earmarked money to that pot, as well as the World Bank.

We have been seeing a real shift over the last few years, where GAVI and the Global Fund did a very particular, tailored bit of health systems strengthening to a much broader interpretation. I like to feel that is because they have been very much involved in the whole donor co-ordination mechanisms in Ethiopia. It is partly due to the incredibly strong leadership of the Ethiopian Government, who are very determined to make sure that the multilateral funding mechanisms work for them, rather than just doing their own thing. It has been very interesting working in different countries over the last 12 years.

We have seen a really large shift, with GAVI and the Global Fund moving towards a much more health systems approach. They are very much talking to each other, and talking to DFID, at country level. Often, because they do not have country presences, they ask us to represent their views and positions in dialogue with Governments. In that way, we also have a chance to influence.

Q131 Jeremy Lefroy: The impact of the focus on specific diseases over the last 15 years or so has been huge: malaria, TB, HIV/AIDS and neglected tropical diseases. As a consequence, the burden on health systems from those diseases, even factoring in population increase, will have reduced. You would therefore expect there to be more resources freed up

by national health systems, to concentrate on other areas, particularly around maternal and child health, and perhaps even more non-communicable diseases and so on. However, what we are seeing in several countries is not just no approach towards the 15% of gross national product to be spent on health—which they aimed for in the Abuja declaration 13 or so years ago—but actually a retreat from that. In certain countries, one consequence of focusing on diseases—and rightly so—through these funds is almost to let countries off the hook. Therefore, are the savings they have seen from a lower burden of those diseases actually resulting in a lower attribution of tax money towards health? That is what the figures in some countries look like. It looks as though, despite increasing growth in most of these countries, they are not putting more into health. Some are putting less into health. At the same time, we have had this reduction in disease burden on those major killer diseases that have affected them for so many years. It almost looks as though they are saying, "Right, we are taking that saving. Thank you very much indeed."

Lynne Featherstone: Yes.

Jeremy Lefroy: Would that be a fair characterisation of some countries, or is that just a wrong view?

Lynne Featherstone: It is quite a job to persuade countries to allocate the appropriate percentage of their budget to health and health systems strengthening. Many of the countries in Africa who signed up to the Abuja declaration have not reached the 5% target that was set. Ministers of Finance are generally, in my experience, the issue. They often need to be convinced that health is a good buy.

We are working hard to build the evidence that investment in health is money well-spent—for example, through funding the Commission on Investing in Health. The Commission report in 2013 showed that there are high economic returns to countries for investing in health. That is not to say, as you rightly point out, that all countries leap at the opportunity to spend that money in that direction. There are Governments that are much better at it, and there are Governments that appear to take an attitude of, "Well, other countries are paying for this; they are tackling it. Why should we put our money in there?" That is work that goes on.

A very important part of our work is influencing and working with health ministries and finance ministries to prove the economic case to them and to continually indicate to countries that it is their responsibility. Public services are their responsibility. That is one of the great challenges. That is why we spend quite a lot of energy also on domestic resource mobilisation, which builds their capacity for taking tax revenue, so that they can actually pay for resources. We also persuade countries to put occasionally less into their security, or other, budgets, and focus more on those that would benefit the many people in need in their own countries.

Q132 Jeremy Lefroy: It seems to me that the key people to influence here are parliamentarians, because, particularly in a constituency-based system, it will be their constituents who see the benefits of a good health system and the problems that come from not having a good health system. What work does DFID do specifically around health—I am not talking about general parliamentary strengthening, although that is another issue—to engage with Members of Parliament to help them understand what DFID and their own

Government are doing on health, and what more can be done. They are the ones who can actually push, as we do here.

Lynne Featherstone: I appreciate that, yes, but most Parliaments are not like ours, in Africa. As we discussed at the last session, 40% of MPs do not ever even visit their constituencies.

Q133 Chair: Part of the reason they do not visit them is that they get people asking them to pay their health bills.

Lynne Featherstone: Indeed, and the systems work quite differently in many ways. In terms of elections and democracy in some of the countries I visit, there is not always a necessity for MPs to visit their constituencies. I very much was struck by your idea of NGOs publishing in each constituency what they do. We engage in parliamentary strengthening, public accounts committees. We are forever trying to build that capacity, and that work goes on. I could not answer specifically here today what we do on health. It is more to do with the whole system. We have, to an extent, focused on public financial management, public accounts committees, audit committees, but I will find out and come back to you.

We have been supporting piloting of results-based financing mechanisms in health that ensure that funds are only spent if services are actually provided. At country level, we work through partners like the World Bank to try to influence resource allocations. I accept that Parliament is one way of doing it, but there are some even more influential ways of doing business in Africa. We are supporting NICE International to help countries build their own capacity to make fairer, more transparent and evidence-based resource-allocation decisions.

Through one of its research programme consortia, DFID is also funding research into how countries can raise more tax revenue for health, and we have worked with the Global Fund to ensure progressive co-financing, willingness to pay and sustainability approaches in funding models. There definitely is a difficulty in getting some countries in Africa to put the value on investing in health that we would put on it, but, as we progress, that argument is holding more and more sway, because, if you do not have the workforce to contribute to the development of a country, that is obviously an economic constraint on that development.

I remember, some years ago, going to South Africa to look at AIDS programmes. That was a time when the Government in South Africa was recommending taking a shower as being the answer. I visited Anglo American mining and SABMiller, because it was the corporates that were active in this field and recognising that, with their workforce dying, it was not altruism; it was a good economic incentive that drove them to provide the most phenomenal facilities for their own employees, supply chains and so on. The country then stepped in, and now South Africa has a health system that works in terms of HIV and AIDS. That is the argument we have to continually make: this is a good investment if you want your country to develop economically.

Q134 Jeremy Lefroy: Finally, is there any sign of organisations such as the African Union taking a lead in naming those countries that have succeeded in reaching the 15%, of

which there are a few, holding them up and almost—I do not like using the word "shaming", but perhaps let us say "shaming".

Lynne Featherstone: Naming and shaming.

Jeremy Lefroy: "Challenging" is a better word—challenging all the others and really informing the electorate and civil society in the countries that are well behind—and we are talking percentages here; we are not talking actual money. I mean, we are talking money, but we are not talking actual defined sums of money. Is there any evidence that that is happening?

Lynne Featherstone: I am not aware of that.

Angela Spilsbury: The African Development Bank held a meeting last year, bringing together the Ministers of Finance and the Ministers of Health from the different countries in Africa to talk exactly about the investment case for health. I know that was quite influential in terms of Ethiopia and Zambia's own internal discussions about what should be done. I am not so aware of the AU, though. They do have a commission on social services and health.

Lynne Featherstone: There are really hard battles that go on, because a lot of the countries I visit are very focused on infrastructure as being the way forward to economic prosperity, so we make these arguments. The only way is to make the economic argument for investment.

Q135 Fiona Bruce: Your written submission emphasises its focus on community health workers and birth attendants, and certainly we have seen some very good work—for example, in Ethiopia—on the health outreach workers there. We have been warned in oral evidence that these fashionable approaches should not be seen as magic bullet solutions for failing health services. Could you anticipate DFID continuing to focus on this or perhaps taking an alternative approach?

Angela Spilsbury: You quoted the Ethiopian experience. The health extension worker programme that has been rolled out there has been incredibly successful, giving a very basic level of services to the majority of the population. In 1991, only 30% of the population had access to health services, which is defined as within 5km of a trained professional. In 2013, 93% of the country has it, so they have achieved universal health care. Again, these health extension workers are very good at being able to do a lot of preventative health care and very basic treatment on things like malaria, diarrhoea and pneumonia, which has definitely been responsible for driving down the child mortality in Ethiopia, and they have now achieved their MDG 4 goal, which is incredible.

However, the Government and we as partners recognise that there is a limit to how much they can do, and, if we now need to try to tackle the bigger issue of maternal mortality, for instance, we cannot do that with community health workers; we need to have a fully trained midwife or doctor who can deal with the complications when they arise, like obstructed delivery or internal haemorrhage. Community health workers definitely have a place as part of a broader system, but you are always going to need a referral mechanism for referring people up the chain to more qualified health workers with more sophisticated services. It underlies why we have to do a health-systems approach, because one cadre or one particular service will never be enough; you need the whole package.

Lynne Featherstone: At the moment, we are looking, in a sense, at tertiary education in a number of African countries because of this very need to have a cadre of internally trained health workers at different levels, whether they are nurses, midwives, doctors and so on, as the country can no longer be supplied at the level they need from other parts of the world. They have to be able to be educated and trained in country to a professional standard.

Q136 Fiona Bruce: In other words, helping countries have a public health system and a strategic approach towards it is really what you are working on across the piece.

Lynne Featherstone: Yes.

Q137 Jeremy Lefroy: Moving on now to making best use of NHS expertise, we have heard evidence that existing schemes to promote greater overseas work by NHS staff are often highly effective, but are fragmented and small scale. Clearly, we have the Health Partnership Scheme, which the Government set up in 2009-10 and has committed more funds to. What is DFID's view on this? Is it seen as a fairly small-scale and marginal piece of work, or is it fundamental to our approach on health system strengthening?

Lynne Featherstone: I think it is fundamentally important, which is why we have the scheme and are continuing to invest in it. I visited a health partnership group—we were trying to remember before where; it began with "W"—in the United Kingdom who go with expertise to a hospital in South Sudan. I visited the Royal Hampshire County Hospital in February 2013.

Chair: You just remembered.

Lynne Featherstone: I just remembered. They work with the Yei Civil Hospital in South Sudan, and it was so fascinating. You, as a Committee, have visited some of these places, and you know that a hospital can be a dirty old room with a bed in the middle and broken windows; it is not necessarily a hospital as you think here. When you say "fundamental", it really is fundamental, because, as well as the doctors, consultants and midwives who went over, and the amazing partnership working, interestingly, this health partnership said the most important member of the team there was the guy who knew how to fix equipment. It was not the medical staff, although obviously they were very important. It was that donors gave equipment to hospitals that lay disused and non-functional because no-one knew how to mend it, drive it and make it work. It is beneficial on both sides, so I would say it is not huge in the scale of our budgeting, but it is a very important link between our National Health Service and those in-country.

Q138 Jeremy Lefroy: I declare an interest in being involved with the Friends of KCMC, which is a consultant hospital in Tanzania. There are real links all over the place between medical schools in the UK and medical schools in developing countries, particularly with a focus on training doctors, nurses, midwives and so on. What support is the Department for International Development giving, and does it recognise that this is one way in which we can counter the brain drain that has taken place over many years of skilled medical professionals into our NHS, from which we have greatly benefited as a country?

Lynne Featherstone: Yes, and we recognise that and feel very strongly about it. We have something called the Medical Training Initiative. That accommodates overseas postgraduate medical specialists to undertake a fixed period of training here in the United

Kingdom for up to two years, normally within the NHS. It is a temporary route, and it seeks to promote circular migration, so that participants in a particular scheme can go back to their home country, taking that expertise and training, and apply the skills and knowledge that they developed in their time here, so that ensures the continued exchange of medical expertise and experience.

We support NICE International to help countries improve the quality of the care they provide. We have started a new programme to make more use of the experience and expertise of NICE and UK universities in building countries' capacities to deliver high-quality care. In 2006, 57 countries were identified as having a critical shortage of health workers, and that was defined as fewer than 2.28 skilled health workers per 1,000 population. Since then, there has been little progress in reducing the number of countries with critical shortages, so it is a real area. The problem is not just one of numbers; it is the actual mix of skills. The national workforces have critical gaps, particularly among non-frontline cadres such as public health specialists and health care managers. I would not even begin to go into mental health care in these countries, which is even further behind.

We make the UK expertise available to other countries through a number of mechanisms. You raised the Health Partnership Scheme, which has recently been extended. I raised NICE International. We have the Making It Happen programme to improve emergency obstetric and newborn care, and the Medical Training Initiative. As I said, one of the things we are looking at is tertiary training in-country for all of those necessary skills.

Q139 Jeremy Lefroy: We tend perhaps to take a slightly silo-based approach. This is all about health, but given that one of the greatest expansions in jobs and livelihoods in the next 20 or 30 years is likely to be in the health and care sectors, does DFID take the view that this is a major contribution not only towards health system strengthening but also to developing better jobs and livelihoods within developing countries? How does that fit in with our economic development programme?

Lynne Featherstone: I think you really gave the answer in your question. Yes, we do, and that is a very important element of higher-grade jobs and opportunities within country, because that is part of our economy development plan. It is not just all jobs but jobs of better quality with better pay and better accreditations, so that does all fit together. As I say, there is a discussion going on as to tertiary education—we are not there yet—in terms of what can be provided or not.

Q140 Jeremy Lefroy: In terms of the Health Partnership Scheme, we are very much focused on volunteers, and that is great. We want to encourage volunteers. I believe the Secretary of State has recently established an African legal fund, which is there to enable professionals, most likely from the UK, to go and support and advise, perhaps on a short-term basis, Governments over contract. We discussed it in terms of natural resource contracts.

Lynne Featherstone: The African Legal Support Facility

Jeremy Lefroy: The African Legal Support Facility, thank you. I wonder if there is an opportunity around health, perhaps at the higher expertise end, where specific gaps are recognised either on the clinical side or on the health systems governance side, for us to set up some kind of similar facility to the legal facility that enables professionals, who might not

otherwise be able to take that time out volunteering because of other commitments, to go on a professional basis.

Lynne Featherstone: I hear what you say. I think there is a critical difference with the African Legal Support Facility, which advises on contract negotiation, vulture funds and those sorts of things, in that there is a high financial dividend from the expertise being dispensed, so that the costs are covered, I imagine. The benefits to the country are huge and immediate in terms of the income that is generated. It is a good idea, in the sense that it would be very valuable to contract out particular specialists.

There are some constraints, though, from our own national health system. We come into areas of how much we can afford to do with our own specialists. There is a national volunteer scheme. In the next few months, there is a plan to launch a new framework for volunteering in the NHS. That is a document that has been developed by NHS International Group, with input from the Department of Health and DFID amongst others. That skills transfer at all levels may be part of the recommendations. I do not know if we would be contracting in the same way as the African Legal Support Facility does, which had to be set up in law.

Jane Edmondson: There are also quite often constraints on the country side, on the demand side. We can deal with supply-side issues, but there need to be demand and willingness there as well. As countries, partly with our help, are strengthening their systems and developing their own regulatory systems, it is about making sure that it is possible to transfer that expertise. We can deal with the supply-side issues, but the demand also has to be there for that kind of expertise. We also work quite often to facilitate that demand.

Q141 Jeremy Lefroy: Has the NHS ever calculated the value to the NHS of the training that they have not had to provide to their workforce who have come into this country to take up jobs? I wondered if that calculation has been done.

Lynne Featherstone: I do not know. We could ask the Department of Health.

Q142 Jeremy Lefroy: It would be quite interesting to find out how we benefit as a country from training given in other countries, developing countries, in their own medical schools, which ends up by being of benefit to our population, and to compare that with what we are doing in reverse.

Lynne Featherstone: We would have to ask the Department of Health.

Q143 Jeremy Lefroy: Is that not something DFID should be interested in, given that this is a matter of development?

Lynne Featherstone: The issue, where this has crossed my path, is that there is quite a moral obligation, having had particularly nurses and midwives come from a number of countries to support our NHS. I doubt whether our NHS could function without some of the input of people who have come here to work in our system. The issue we would be looking at is how we can develop those countries, so that health workers want to stay in their own country and not come to this country. I am sure we have benefited, and we are looking at where advertising is done and whether anything that is advertised should be

advertised here, not to draw people in in the same way. I do not think that is something we have focused on as a sort of quid pro quo.

Q144 Chair: The Committee, when it did its post-2015 report, supported the case for a universal health coverage objective or goal in post-2015 outcomes. Do you agree that this is a desirable idea and that, if you did have it, it would incorporate strengthening health systems as part of the mechanism?

Lynne Featherstone: This is a discussion that we are having at the moment. The United Kingdom's position is that the goals should be outcome-based.

Q145 Chair: Sorry, does that mean yes or no?

Lynne Featherstone: It means that, while we absolutely support universal health coverage, we are not sure that having that as a goal would be the best way to get to universal health coverage. We think that outcome-driven has been proved by the last MDGs to be more of a driving force than a goal that does not demand an outcome focus. I do not think there is a difference in the ambition; there is a difference in how we think we should get here.

Jane Edmondson: We support universal health coverage as a target underneath the goal that focuses on health outcome, and that is our current statement in the Open Working Group for the post-2015 goals.

Q146 Chair: That implies that you would not just say, "We support a universal target." You would say, "in order to achieve agreed outcomes" or something. You would want to reinforce in that way. A particular point has been made to us that the proposal going around at the moment does not appear to include a specific target for women's health, which is surprising given that is one of the key targets that was in the existing Millennium Development Goals.

Lynne Featherstone: I would be very surprised. Are you certain it is not under the gender goal itself? I do not know.

Q147 Chair: The point has been made that it is not explicitly attached to the universal objective. These are all obviously under negotiation and in transition.

Lynne Featherstone: These are all under discussion at the moment, but I would not want that to go ahead without a woman's health goal being there. I am sure it will be under the stand-alone gender equality goal, but we need to make sure that it is mainstream, because it was meant to have a goal in itself, plus be mainstreamed across all the other goals. That is the United Kingdom's position. If it has been accidentally missed, I am sure we are still going to be lobbying for it.

Q148 Chair: Thank you very much. It has been really useful to explore this strengthening of systems by vertical outcomes. There is quite a bit for the Committee to reflect on as to what are the most useful recommendations we can make that pull those two things in.

Lynne Featherstone: I guess it is not either/or.

Chair: No, it is how you make them work together more effectively, so that one reinforces the other.

Lynne Featherstone: It is always a pleasure to appear before you.

Chair: Thank you very much.