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International Development Committee

Oral evidence: Health Systems Strengthening, HC 246

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Watch the Meeting

Members present: Sir Malcolm Bruce (Chair); Fiona Bruce; Sir Tony Cunningham; Fabian Hamilton; Pauline Latham; Jeremy Lefroy; Sir Peter Luff; Mr Michael McCann; Fiona O'Donnell;

Questions 1-56

Witnesses: Dr David Evans, Director of Health Systems Governance and Financing, World Health Organization, Dr Andrew Cassels, Senior Fellow, Global Health Programme and Professor Kara Hanson, Head of Global Health, London School of Hygiene and Tropical Medicine gave evidence.

Q1 Chair: Good morning, and thank you very much for coming in to give evidence on what is the first oral session we are having on this Inquiry into strengthening health systems. I just wonder, for the record, if you could introduce yourselves.

Dr Cassels: Good morning. I am Dr Andrew Cassels. I worked for 15 years for the World Health Organization, which I left three months ago. I am now working independently, both as a consultant and as an academic.

Professor Hanson: I am Kara Hanson. I am Professor of Health System Economics at the London School of Hygiene and Tropical Medicine.

Dr Evans: I am David Evans. I am Director of the department of Health Systems, Governance and Financing at the WHO. I have to admit that I am Australian.

Q2 Chair: Welcome. Thank you very much. Obviously, what we are looking at is partly the competition between strengthening health systems and delivering targeted outcomes, and whether or not they are mutually exclusive, or need to be, and how you weigh the balances.

To get the ball rolling, DFID have talked about strengthening health systems, but do you perceive over the last few years that they have actually changed their emphasis and their approach in that way? Or has there been too much more focus on disease-specific targeting? When we had an inquiry into this before, we had this stuff about vertical, horizontal, and then this nonsensical diagonal approach. Do you see a difference in the emphasis between strengthening health systems or delivering these vertical targets?

Dr Cassels: You are all looking at me; I'll start. My sense is that there is certainly a difference in the way that DFID talks about its health programmes, with a focus on results and quite a narrow focus on health outcomes. However, looking at a lot of the work, it is clear that the bilateral programme is still paying quite a lot of attention to health systems issues. I do not think that has changed massively, from the few countries that I know and from discussions with advisers in my past job, whereas I think with some of the multilateral work, the focus perhaps has changed. I think that given the circumstances at the moment, it is quite attractive to put quite large amounts of the programme through multilateral organisations—or the new hybrid partnerships like GAVI and the Global Fund—that talk quite a lot about health systems, yet the scope of their health systems work is quite narrow and quite tightly linked to a few outcomes for which they are mandated. I think that is an issue.

Also, there has been a change in many of the other agencies involved in health work, with a focus on things like results-based disbursement, particularly on maternal, new-born, and child health. Specific funding mechanisms have been set up for those outcomes. There the focus has shifted towards a quite narrow set of results.

Chair: I should just say that we are going to be very constrained for time, because we have got two panels and we are going to have to finish by 12. I do not want you to stop you from saying things, but we will not get to all our questions.

Professor Hanson: I suppose one of the changes we have seen from a researcher's perspective is an increased focus on quick results, and quickly getting research into policy and practice. That makes it very challenging to do research that generates new ideas, and that changes the way that people talk about topics and issues. There is a tendency to focus on quite narrowly-focused question that do not speak to the broader issues of health systems development

Dr Evans: Like the others have said, I think there has been a change, partly because of this emphasis on results and the need to prove that taxpayers' money is being used appropriately. That does require one to narrow down on a very narrow set of questions: "How many women's lives have been saved?" etc. My perception is that, whether we like it or not, in some sense the need and the recent practice of trying to scale up a lot of interventions for AIDS, TB, Malaria, child and maternal health—and now for new diseases such as NCDs as well—means that we do not really have a choice. We are running into the constraints now where the quick wins have been made, and we are not going to be able to get more quick wins. We are not going to be able to keep scaling things up without addressing the constraints and the bottlenecks now.

Q3 Fabian Hamilton: Good morning. I wonder how you would characterise the approach of other development agencies and major donors to health systems strengthening. Do you think it is fair to say that they tend to favour a more vertical approach, and what influence do major private donors such as the Gates Foundation have on the way DFID money is spent, do you think?

Dr Cassels: I think with many of the other donors, including the Gates Foundation, there is a focus on quite narrow, short-term results—more or less in the way that David Evans was just describing. I think that has influenced DFID, perhaps more through its multilateral channels than through its bilateral channels. The country programmes run by DFID, from

the ones I have seen, still keep the notion of strengthening systems in order to produce results in the frame. However, the pressure is very much to talk about the results rather than the systems issue. On the Gates Foundation, I think it has been a struggle to get that group interested in the more systemic issues, rather than just finding technocratic solutions to getting results.

Q4 Fabian Hamilton: Do you think the Gates Foundation does have an effect on the way DFID's money is spent?

Dr Cassels: I find that one difficult to answer because I do not have the budgetary knowledge. I would be surprised if it did not, but I do not have that evidence.

Professor Hanson: That is a very interesting question. In some sense, Gates leads. Where Gates goes, it does act as an indicator as to where others should follow. The Gates Foundation talk about themselves very much as being gap fillers. They hope that once they have chosen a path of action that leaves clear space for others. So, I think again the empirical evidence of what happens in practice is somewhat lacking.

Dr Evans: Just a very quick addition: with the emergence of Gates with the big money, and perhaps Norway, for example, with a lot of money, a lot of agencies including our own get influenced by where the money is. The pressure from Gates and the pressure from Norway to move in particular directions has been pretty strong, much of it for good.

Q5 Jeremy Lefroy: Ten days ago in Sierra Leone I saw a bed net distribution programme going on. The whole country was covered in two weeks through the existing network of health centres. That bed net distribution was funded substantially by DFID, but also by other donors, and probably indirectly by some of these multilateral organisations. What would you say when multilaterals such as the Gates Foundation, and GAVI and the Global Fund, say that they focus on systems strengthening? Have you seen that in practice, as I have?

Dr Cassels: I was part of the advisory group to GAVI on their health systems expenditure. The impression that we got as a group was that much of GAVI's spending on health systems was inputs into a health system—vehicles, cold chain equipment, refurbishment of buildings—that, in a sense, does not necessarily strengthen the way the system operates. It provides the materials that health systems need, without necessarily changing the way they work. As I mentioned earlier, their health systems work is increasingly focused around immunisation coverage. That is fine and a good thing, but it needs to be much clearer that that is the case, because it then opens the space for others to come in on health systems work. If the Global Fund and GAVI, by their boards, say they are committed much more broadly to health systems, it gives the impression of something greater than what is actually happening.

Q6 Jeremy Lefroy: Just following on, you have already referred to the fact that, bilaterally, DFID is often stronger on health system strengthening than possibly some of the work that is done through the multilaterals. How do you think DFID could encourage a greater commitment to the horizontal as opposed to vertical from the multilateral organisations? Perhaps one of the other panellists could answer.

Professor Hanson: There is a challenge as to whether those organisations have the required expertise both in their head office but also whether they have a presence in country that will allow them to support those kinds of investments.

Dr Evans: It is probably also a question of which multilateral institutions DFID chooses to invest in. There have been a number of new, small multilateral institutions set up for one particular disease or one particular disease complex. While they talk about investing in health systems, their capacity to do that is relatively small, and linked to one particular disease. So, it is probably more a way of choosing which places to invest, and then saying, "Yes, one needs to think across all the different components of the health system as well". Because one does not want to verticalise health systems. If you just do health workforce, for example, and do not get the financing system right or the medicine distribution system right, you are solving one small part of the system. We need to also think across the different components of the system, and understand in each country where the bottlenecks are and where those constraints need to be met, rather than saying, "Okay, we have got a solution in one area", which might not be relevant to many countries.

Q7 Jeremy Lefroy: If I could finally just take you back to the time before the turn of the century when these big vertical initiatives really kicked off. Presumably, you would then be saying that DFID was very good on health systems, and yet millions of people were dying unnecessarily from malaria, HIV/AIDS and TB, who are not now. How can we make sure that those gains are sustained, and not just drift off into a waffle about health systems strengthening that loses the focus on diseases?

Chair: This is a serious inquiry, Jeremy; it is not waffle.

Jeremy Lefroy: I maintain my word, "waffle", because that is what it can be. It can be a lot of words and no action.

Dr Cassels: Absolutely. I would agree with you. I was involved very much in the setting up some of the vertical programmes. The aim there was to get much more money into health work generally, because it was pretty clear from the leadership of UNAIDS and from the WHO that we were not serious about the quantum of resources needed to really be serious about health. Getting the Global Fund, the G8, and the private sector involved was necessary.

That does not change the basic argument, where DFID was a real leader in saying, "To do this, you have got to tackle some of the systemic institutional issues that prevent projects working well, whether they are on a single focus or a much broader focus". DFID, in those days, was very much a thought leader. I was asked at a retreat of advisers how the outside world sees DFID now. The response, I felt, was that we have slightly lost that thought leadership from DFID that used to be there. When the advisers came back to me, answering the question, there was a strong feeling that they were bound up in so many of their own process issues, particularly about looking at value for money, that it was very difficult to have any space and time to look at some of these bigger picture issues about aid effectiveness or health systems development.

Q8 Fiona O'Donnell: I would defend Jeremy's right to talk about "waffle", because I think that perhaps a vertical approach when it comes to diseases is actually effective. How do you halve deaths in malaria if you have not strengthened health systems. I wonder, in terms of the Millennium Development Goals and the targets they had, which very much focused on vertical programmes, whether you think that was at the expense of systems strengthening? Looking now to the post-2015 framework, which is a broader health goal and then sub-targets attached, is that a better approach? From what I have seen, it still does not talk about health systems. Should there be targets, for instance, for a certain number of birth assistants per number of women—maybe one per 100 women in the country—and health workers per 200 people in the country? Would having goals that directly look at that be a way of building it into the post-2015 framework?

Dr Evans: Trying not to waffle—

Sir Tony Cunningham: You have started something now, Jeremy.

Dr Evans: The way that we have looked at it in the WHO is to try to build the health systems component through this thing that we call universal health coverage, which builds on what we perceive as the population of every country wanting. They are asking, "Are the services available? Are they good quality? Are they affordable?" That is universal health coverage. If you can track that, you are tracking the achievement of the health systems; are people who need to deliver in the presence of a skilled birth attendant getting that? If they get that, then you have got sufficient skilled birth attendants. So, rather than go into all of the components of the system of, "Are there enough medicines? Are there enough health workers? Are there enough facilities?" we perceive the coverage within health services, and the financial risk protection, as being the way of trying to build that broader perspective into the goal of achievements in the disease-specific areas. That is where we perceive it at the moment.

Professor Hanson: I would say that indicators are powerful; they provide a focus. However, I believe there is a saying that once you have started to use something as an indicator, it no longer becomes a very good indicator because it becomes such an element of focus that other things get left by the wayside. Having such a broad indicator around universal health coverage will help to ensure focus on many components, where very specific ones will almost certainly divert effort to a narrow approach.

Dr Cassels: My sense is that in the post-2015 agenda the MDGs have been incredibly powerful and incredibly influential in terms of money and political attention. To have an inclusive health goal is important. The danger is that the stakes are so high that individual institutions will fight for their particular goal or their special interest, and you will get a fragmented health goal. At the moment, I think we are in quite a good place. The way that the open working group are describing it at the moment involves a fairly inclusive approach to health, with some targets that are more specific, and that hopefully do not divide up along the institutional lines of UN organisations, which is a temptation.

We could lose it quite easily, because there are three or four divisive issues that could really make it more fragmented. Reproductive and sexual rights will always divide the General Assembly. IP—intellectual property—and trade issues on access to medicines are going to be the hard-fought areas in keeping the health goal together and universal coverage in the frame.

Q9 Mr McCann: Good morning. Could I ask you some questions about DFID's expenditure profile? Because there are conflicting figures about how much DFID actually spends on health systems strengthening. Do you think a certain proportion of DFID's health budget should be dedicated to systems strengthening, and if you do, what do you think that proportion should be? I do not go for waffle; I go straight in for specific questions.

Dr Evans: Yes, in the first part. There needs to be some clear attention to health systems strengthening. I suspect I will waffle a bit on the second part. It is very hard to say what proportion, I think. I would prefer to focus on understanding what the constraints and bottlenecks are. For example, there is a lot that can be done to improve the efficiency of health systems everywhere, even in lower-middle income countries. Now, DFID has programmes on results-based financing and technology assessment, which are just small parts of improving efficiency overall. However, if they asked, "How do you help countries improve their own efficiency?" and allocated the budget to that, that would have major pay-offs. I have not answered the second part of your question totally, but I would go on a problem-by-problem approach, as opposed to the overall.

Dr Cassels: I would basically agree with David. I think it is very difficult having a totally separate budget for health systems. I will use the parallel in the WHO, where the danger of having a health systems group or a proportion of the spend on health systems alone, isolates it. If you are going to improve maternal mortality, you need to tackle systems issues. It has to be looking at the overall results, but also looking at the ways you are improving performance of systems along the way. It is hard getting that actual figure of what is really a health systems issue.

Q10 Mr McCann: I will make two statements. The first one is that the more money we put through multilateral systems—and DFID puts huge sums of money through multilaterals—the less money is spent on health systems strengthening. Would you agree with that? My second statement would be that there are still massive efficiencies to be gained in areas like the Global Fund, who stand accused of inefficient procurement of resources. Where would you stand in terms of those two statements?

Dr Cassels: On the first statement, I would say that I think you are right, though you need to distinguish between different types of multilateral expenditure. I was struck when reading the DFID health position paper how much the authority of that paper depends on data from the WHO: "The WHO says this, this, and this", repeatedly, right through the document. However, that is the hardest part of the WHO's budget to actually finance, because the way that the bilaterals push the WHO system—and DFID is not alone in this—is towards being like them and delivering programmes on the ground, with a clear line of sight to poor people, etc, and away from the activities where those multilaterals actually have a unique role in terms of normative work and monitoring health standards worldwide, etc. This is as opposed to the hybrid funds—GAVI and the Global Fund—which we have covered already, where I think the health systems remit is quite narrow. It would be good to be clear about that narrowness. In terms of the Global Fund and procurement, I will pass on that one, because I do not know the Global Fund procurement system well enough.

Dr Evans: Just to add to what Andrew has said, there are other ways to fund multilaterals. DFID has ways of giving budget support to the multilaterals, but also specified funding. I have to admit a conflict of interest. DFID has funded my programme over the last four years to help countries develop health financing systems, to improve their efficiency, to raise more money, to pool it, and to reduce out-of-pocket payments. All of that money goes to health systems strengthening in countries. So, there are ways that DFID can fund the multilateral agencies as well that do not result in that loss that you described.

In terms of the Global Fund and other activities, from a financing perspective, the way money flows determines the inefficiencies and the way their system operates. Where money still flows to AIDS, TB, and malaria separately, you are going to have these inefficiencies. There will be labs for TB built side by side with labs for AIDS, because of the hierarchies and bureaucracies that the funding flows create. The new funding model of the Global Fund is very promising, but we have not quite got the funding flows more centrally that will avoid and eliminate some of those inefficiencies and mechanisms like you said.

Q11 Sir Tony Cunningham: I would like to ask one or two questions on research. Could I preface it with a question? Just out of interest, I wonder what proportion of your time is spent on research in this country and what proportion of your time is spent in-country?

Professor Hanson: Just to clarify, do you mean research on the UK or research in the UK?

Sir Tony Cunningham: My first question is on how you would characterise DFID's approach to health system research. The reason I preface it is that quite often we are told by an NGO that this is wrong, and this is bad, and you get to the country and it is different. I just wonder what sort of research is done.

Professor Hanson: First of all, I would say that DFID has been a leader in health systems research. They have a number of mechanisms through which health systems research is conducted. One of them is through the research consortia model, which I am personally most involved in because I co-direct one of the health systems research consortia. We have a programme of six years. We are a consortium of 10 organisations altogether, only one of which is in the UK. All of our other consortium members are based in other countries. The vast majority of funding is channelled to those organisations. The way we work is through a network model. I personally travel to do research in a developing country for something like 20% of my time, but I work very closely with leading researchers in those settings; we work together to develop programmes of research. That RPC model is really important.

A second model that DFID uses is to support the Health Systems Research Initiative. That is co-funded with the research councils: the ESRC, the Medical Research Council, and the Wellcome Trust. They are just currently considering their first round of applications. This is another incredibly important vehicle, because not many research institutions and very few other bilaterals fund health systems research in the same way.

Q12 Sir Tony Cunningham: Is enough known about what works and what does not in health systems strengthening, and could DFID do more to increase the stock of knowledge?

Professor Hanson: A study in 2007 looked at research grant programmes in the area of child health, and found that 97% of the spend by the major public and private funders was about development of new interventions. Only 3% was about how to deliver those more effectively and how to ensure access. So, I would say that in general, the quantum of resources going to explore these issues about how to deliver effective interventions is simply insufficient. Having said that, there is a knowledge base. We know a lot, through DFID funded research, on user fees: on the impact of user fees on poor people and how to remove them effectively. However, health policy agendas change and now there are many new questions arising around the areas of health financing, how to achieve universal health coverage, and what sorts of financing systems work. There needs to be a continued effort to generate evidence to support these new policy initiatives.

Q13 Sir Tony Cunningham: My final question in this area: where research exists, how effective is DFID at acting on it, disseminating it from the centre, and most important of all, sharing best practice across country teams?

Professor Hanson: Part of my source on this is a report that you know—the ICAI report on how DFID learns, which did raise some questions about how effective DFID is at sharing information amongst its programmes. My own experience is that DFID advisers are keen on evidence. They like to engage with evidence, but they are highly constrained by the demands of working in country offices when seeking to access it and use it effectively.

Dr Cassels: Could I just pick up on the "What works?" question? DFID is financing a very interesting programme in China, which is helping universities and the Government in China to synthesize experience in that country, where quite a lot of things have worked in terms of health and lifting people out of poverty. This programme involves working with a consortium of Chinese universities, UK universities, and universities in Africa, and then bringing that experience to bear on lower-income countries. For a very modest spend, the programme is actually making the experience of a country like China available much more widely, and at the same time building up institutions in China to become much more effective players in the whole world of global health.

Sir Tony Cunningham: Any comments, David?

Dr Evans: Not at this stage, thanks.

Q14 Jeremy Lefroy: Could I ask, broadly and then maybe with some more specific examples, what work DFID is currently doing on strengthening the finance for health systems?

Dr Evans: The work that I know about is linked to trying to help countries review what their health financing systems are. This is linked to what I said earlier. It is about asking, "What prevents you from making sure the services that people need are available, good quality, and affordable?" It spreads across questions such as, "How do you raise more money for health?" Kara is involved in some of this work that is trying to say, "Look, there are options for raising more money for health." We tend to work through all of the

options with the countries, including tobacco and alcohol taxes—taxes on harmful products—but not only that. There is also a question around how you use pre-payment and pooling mechanisms to reduce out-of-pocket payments. You probably saw some of the work that DFID have done Sierra Leone and Liberia, but there are a lot of countries, such as Thailand, Rwanda, Burundi recently, and Ethiopia, that are moving towards reducing out-of-pocket payments through pooling. They are trying to build that pool to spread risk across a larger proportion of the population.

Then there is the work on efficiency and allocation, which asks how you improve efficiency in the system. A lot of countries are now focusing on understanding their sources of inefficiency. There are multiple sources, but we tend to work with them a lot on things like medicine distribution systems, medicine purchase systems, and the rational use of medicines. Many of these things waste money. Financial management, stopping corruption, and accountability are other ways of improving efficiency. I am familiar with that work. A lot of DFID's involvement in that—not just through my organisation but in the countries themselves—will hopefully lead to long-term financial sustainability. As countries grow, they are going to be able to take on more and more responsibility for funding their own health systems, in a way that people can afford to pay.

Professor Hanson: To add to that, within our research consortium we have been looking specifically at this issue around how countries raise more tax money, and whether that money gets effectively allocated towards health. We have found some very interesting examples of countries that have been able to raise more taxes without raising tax rates. In fact, South Africa has reduced corporate tax rates and has still seen the take increase. It is clear that governments can be supported to raise more domestic resources. However, we have also found that in the three countries we have looked at, none of that has gone to health. A really critical challenge for ministries of health in this area of financing is finding ways to make a better case for health, when they are themselves going through budget rounds and negotiating with ministries of finance and ministries of planning. Helping health ministries to develop that expertise and that language to make the case is something that DFID can certainly contribute to.

Dr Cassels: Coming at it in a slightly different way, one of the problems in health systems is that you have got many different donors in countries, often pushing in different directions with different sets of priorities. One of the roles that DFID has been quite strong in is helping governments coordinate that diversity of donors more effectively, certainly through the medium of things like the International Health Partnership, but even in countries that are not involved in IHP. It has been in very much a leadership role. I was recently in Myanmar where you have got a sudden influx of new development partners and a Ministry of Health that has limited capacity. There was very much a need on the donor side to try to get everybody singing from the same sheet and pushing towards a much more systems-oriented agenda. DFID has been extremely influential in that particular country. More broadly, through the IHP and others like it, it can make sure that external financing is much better aligned to national priorities rather than being driven by other factors.

Jeremy Lefroy: I would certainly endorse that from visiting a couple of health ministries last week. In one case, you just saw the queue of people waiting to see the Health Minister, which was a complete waste of their time—I would say on both sides.

Mr McCann: And ours.

Q15 Jeremy Lefroy: And ours, yes, in one case. Could I then talk briefly about the Abuja Declaration, which many countries have signed up to, which is an agreement that they will spend 15% of their government budgets at a minimum on health. How many countries have actually achieved this, out of those who have said that they should achieve it?

Dr Evans: Four or five last time I looked, out of the 48, roughly. Since the Abuja Declaration in 2001, roughly half of the countries have gone backwards and not even approached the 15%.

Q16 Jeremy Lefroy: So, given that this is something that is entirely within their own control, is this not something we should be a bit tougher on? Should we not say, "We do not really see why we should continue to support you if you are not prepared to do it yourselves out of your own resources"?

Dr Evans: I personally think that there is good reason to say that the countries can raise more money for health if they really want to. It is not just in allocating more of the budget to health but, as we said before, of raising more money or getting better with tax collection. The tax efficiency is really bad in many of the countries. So, these are ways of raising more money, some of which could be used for health. I would certainly agree that they could do more.

Q17 Jeremy Lefroy: Would the logic actually be that the best thing that DFID can do for health systems strengthening is help them to improve their revenue collection? This is, in fact, what DFID is doing in many countries. That is probably the single most important thing they could do.

Professor Hanson: The evidence that we have uncovered through our research is that that is necessary, but not sufficient. There is a political process that needs to be engaged in and supported, around advocating for a greater share of that revenue to be allocated to health.

Dr Evans: If I can add to that, revenue collection is only the first part. If you do not have a pooling system to spread risks across a population, there are going to be people who cannot afford to pay. So, linking the revenue collection to the way of pooling and pre-payment, how you raise the revenue, and who benefits from it—and then the efficiency side—is really important. They have all got to be done at the same time. I agree that getting the efficiency in the taxation system is really important.

Dr Cassels: One other factor to add is that a large number of countries, particularly in Africa, have continued to grow. Domestic resources are going to be increasingly important and external finance is going to become less important, or it is going to become more concentrated in the really difficult environments: the countries where Government either cannot or does not provide for the health of their citizens.

In those countries the management systems are at their weakest, and there is a need therefore to either set up parallel systems to guard against losses, or to take risks. Because working in those very difficult environments is much riskier. It seems to be to be a

necessary corollary of the concentration of aid into increasingly difficult environments that that will happen. There is a choice to be made: do you run everything through separate, parallel systems to safeguard finance, or do you recognise, as the country environment gets more difficult, that you have got to be prepared to take more risks?

Q18 Jeremy Lefroy: Could I just turn to a slightly different issue, but one which is very important? How much do you think that the UK's own system for financing health, rather unique among developed countries, influences DFID's approach towards what it encourages other countries to adopt?

Professor Hanson: In my experience, DFID does not per se argue in favour of a tax-funded system. However, it does very strongly advocate for the importance of pooled sources. Sometimes people are confused in their discourse about whether they are talking about health insurance, or providing an insurance function. A tax-funded system like the UK, or a social-health-insurance-funded system like other of our European neighbours, are both equally able to achieve that insurance function. In my experience, the advice that is given to countries is fairly even across those options. The emphasis is really around ensuring that that insurance function is provided.

Dr Cassels: I was working closely with DFID at the time of the former Soviet Union, and there was a rapid shift to using many more experts from the National Health Service. Sometimes this worked very well, but other times it tried to transfer the model that happened to be very current at the time, involving the separation of purchasers and providers, which did not necessarily work in the institutional environments that it was being suggested for. My sense is that there is the potential for really interesting links between the NHS and many developing countries. This includes things like the clinical pathways work that NICE International are doing in India and also in China, which helps to use the experience of this country in making health systems more efficient. However, you have to have a good professional judgment about their applicability in the institutional environment where you are trying to transplant them, particularly with low information.

Q19 Jeremy Lefroy: Just one final question: the World Bank has been experimenting with results-based financing, with DFID's support. I wondered what your views were on that, and what role such an approach should play, if any.

Dr Cassels: You start, because we discussed it on the way here.

Dr Evans: I would go back to what I said earlier about efficiency. I think inefficiency in health systems is a fundamental problem everywhere. Addressing the main ways of doing that is important. Sometimes, where the results-based funding lobby—and I am not saying DFID—have got it wrong is that they have come into a country with a solution that may not be that country's problem. If you come in with a solution without understanding what the major causes of inefficiency are and how you can deal with them, sometimes it goes wrong.

With results-based funding, I think it is a good idea that people are influenced by financial incentives as well as other incentives. One has to be careful, because one has to be able to track what they are doing and what they are not doing. Often, they have only tracked what they are doing. The research on it has tended to say, "Yes, if you pay people for

delivering babies in hospitals then there are more babies in hospitals". They have not looked at what people are not doing. When they did it in the UK with paying GPs, they had to modify the incentive system because people adapt their behaviours. If you do not have an information system that allows you to do that, you can change behaviours in ways you do not really anticipate. However, I think in principle it is a good idea. It is one contributor to improving efficiency, but it is only one.

Professor Hanson: I would agree with that. The evaluations of results-based financing and pay-for-performance have answered some of these first-generation questions, such as: "Does it work on average for the things that you pay for?" The answer is yes, on average, for the things that you pay for. There are a whole sequence of really important second-generation questions that are around how this is going to work over time, and whether country systems are nimble enough to be able to adjust the targets as they are achieved, or whether the system will just roll on into a new low-performance equilibrium. There are also questions around what will happen as we become concerned with a broader range of services. The targets have to be narrow; you cannot measure everything. However, when we want to start adding more and more services, do we effectively end up paying for everything? Is it possible to have a pay-for-performance system that takes a more comprehensive approach?

Dr Cassels: I would just add that the results-based experiment is not the whole of the programme of the World Bank. I think one of the positive things is that the Bank is becoming much more active in the health sector, largely from a health systems perspective. It has been relatively quiet, and has been overshadowed by some of the funds in the past. I think that under the new leadership it is an important ally for DFID, and that relationship is an important one, with influence flowing in both ways.

Chair: That is not entirely surprising.

Q20 Mr McCann: What mechanisms are in place to ensure that resource allocation and prioritisation take place in developing health systems? Given that the World Health Organisation estimates that between 20% and 40% of health resources are wasted, what is going wrong?

Dr Evans: Part of the answer is technical—or part of my response is technical and part of it is political. It is easy to identify the sources of inefficiency. It is more or less easy to quantify them. It is much less easy to do something about it, as most countries know, because a lot of people have a stake in the current inefficient system. So, every time you try to change something there is an interest group that wants to stop it, and the political complexities start.

We have been trying to do some work on not just identifying the sources of inefficiency but helping countries to address them. It just takes a long time because they have to go through this policy dialogue, and get the different groups involved. So, that is part of the problem: there is always some group that benefits from an inefficiency. If a country is paying too much for medicines, for example—and some countries are paying substantially too much for medicines—someone is benefiting from that higher price. Who is it, and how do you change that? How do you get that political balance right? That is one of the problems. It is easy to identify, but getting the political system to address that takes some time. In some countries, the national health system has been a continual drain because

there is an incentive to overproduce services, and there is an incentive to provide too many services to too many people, because that is the way they are paid; that has been a problem that they have been trying to address for some years.

Q21 Mr McCann: We have got 28 bilateral programmes. If DFID was aware of a country where the type of problem that you have just described is taking place—where they are paying too much for drugs—surely that is the point where we should be stepping out and saying, "No, sorry, stop; it is not happening"—whether it is through the bilateral programme or indeed the multilateral programme?

Dr Evans: I agree.

Mr McCann: But it just is not happening.

Dr Evans: I cannot say that there are DFID programmes paying too much for medicines. I can say that there are countries that are paying too much for medicines, or not distributing them appropriately, or they are going to waste, or they are using too many antibiotics, or prescribing too many medicines. It is easy for a donor to say, "Okay, in my particular programme we will insist on this", but to get the health system not to waste medicines, or to use them appropriately, is perhaps a bit more complex. It requires DFID to be able to interact with the individual in the ministry, or whoever is controlling the supply of medicines, or doing the purchasing, etc.

Professor Hanson: It is important to distinguish between efficiency by doing the right things—so, choosing the right interventions: delivering services that are cost-effective and known to be cost-effective—and doing those things well: making sure that there is no waste in the production of those services. There is certainly lots of guidance on how countries can select priority interventions. Countries will have access to things like the disease control priority process that systematically gathers evidence about cost-effectiveness. They do have access to previous versions; they will have access to new versions of it. This can guide resource allocation. Then, thinking about the process by which those decisions are made again goes into politics. These are political processes around resource allocation.

Q22 Mr McCann: Perhaps I could throw this into the mix before Andrew comes in. NICE International have been quite scathing, because they have said that ad hoc decision-making on budget is "driven more by inertia and interest groups than by science, ethics, and the public interest". They are suggesting that decisions have been taken in healthcare in the developing world that are not even cost-effective in the wealthiest countries in the world. Is that something that you also recognise?

Dr Cassels: Certainly for the WHO it is a huge issue. Poor purchasing decisions are not confined to low-income countries. I was going to use a slightly different example of the relationship with work in the private sector and private sector investment, where health was one of the sectors that they were very interested in. They were looking at an example of that in India where the private sector group were working separately from the health group, investing, in this particular instance, in a diabetes hospital. On a field visit, the medical officer in charge made great play and said, "We do not use generic drugs here because we are dealing with a slightly more middle-class clientele and they do not

appreciate the use of generic drugs". When this was reported back to the health advisers, there was clearly a need to bring those two together.

So, yes, we do need to invest in private facilities because they are a major source of care in many countries. However, it needs to be informed by public health principles. There they were operating very much separately. So, there are ways of getting at this. As David said, a lot of the problems are around vested interest, but there are still things that can be done within individual programmes to get slightly better responses. It is also true that some of the answers are not always at country level.

Professor Hanson: I would just take us back to an earlier question about which drugs and technologies the health service should pay for. That is part of the question. Harking back to a conversation we had earlier, the choice of the technology and the technology assessment function provided here by NICE are only part of the system. You need to look back at the broader health financing system, and what the incentives are for healthcare providers to do certain things. That is at least as important a determinant of efficiency and effective resource use within health systems. It goes back to a health systems strengthening issue.

Q23 Sir Peter Luff: Good morning. One of the themes in the written evidence we have received is the importance of good governance in health systems, which I would say, not wishing to disagree with my good friend Jeremy Lefroy, is more important than money. How you spend it is actually the fundamental point. The Malaria Consortium wrote that because of this lack of attention to leadership and governance, there is a "proliferation of global health initiatives that have caused challenges for developing countries to invest in their own priority health issues". NICE International is critical of DFID in a sense, because they said that DFID has tended to neglect "messier governance strengthening and institutional capacity-building initiatives". What is the role of development agencies in helping to achieve good governance in developing countries?

Dr Cassels: Certainly for DFID it is an extremely important issue. Governance, in the sense of coordinating all of the different development partners, as I spoke to earlier, is something where DFID has had an influential role and is critically important. The proliferation of new global health initiatives that you have spoken about has been with us for the last 10 years. It has come on the back of an increase in aid funding, because the temptation is to set up new channels and new systems for each particular problem. I think it is unlikely to get better, and I think it is unlikely to go away. Therefore, there is a challenge to govern it better.

There is also a governance function where development agencies like DFID can play a role—given the impact of other sectors on something like malaria—on trade, on housing, and on agriculture. Governance in those sectors can also impact on health. DFID has a role not just in individual countries trying to help with coordination, but also globally in terms of the negotiations around different aspects of sustainable development, where health is influenced positively or negatively by what happens in other sectors. There is a governance role in both of those things.

Q24 Sir Peter Luff: It is an obvious question to ask, and perhaps a foolish question, but what is good governance in health systems? Prioritisation is also important for governance, for example.

Dr Cassels: As you say, it is making sensible use of the assets at your disposal in a fair way, and in an efficient way, broadly speaking. Much of what comes under the coordination role is a response to the fact that this proliferation and fragmentation is not efficient, it is not effective, and it wastes effort.

Q25 Sir Peter Luff: You spoke earlier about DFID having lost its thought leadership in some areas of health. What is NICE International's reputation in this area?

Dr Cassels: It has been perceived very much as a UK institution. It could do well by giving more attention to its international work. I know of the work in India, but I think it has the potential to get a lot of interest in other countries.

Professor Hanson: Some of the work that NICE International is doing is excellent. Some of the models of a health technology assessment decision-making structure are possibly more appropriate for middle-income than for low-income countries. There is both a question about how decisions are made, but also a question about the allocation of scarce resources, and here I mean the national analysts who are able to engage in these technology assessment processes. That works fine in middle-income countries where you have a certain volume of economists who can do this work. I think in low-income countries you are often taking people away from perhaps more important roles.

Dr Evans: If I can just add briefly that I think the decisions that NICE makes in the UK are really important. It assumes that a financing system exists where everything has more or less been decided about what is already there. NICE then makes incremental decisions about whether we buy a new technology or a new process, or whether we subsidise it. I agree with Kara that those are the sorts of questions that some of the middle-income countries are now asking. Yet in very low-income countries they are not asking those questions. They are asking, "What do we do at the primary care level? Do we do a mix of impregnated bed nets? Do we mix it with indoor spraying? Do we mix it with prophylaxis for pregnant women? What happens if I do them all together?" That is a different sort of technology assessment. NICE are very clever people and I am sure that they could do that. However, they have not had to have that sort of thing in the UK, where you ask, "If I do this combination at this level of the system, what happens?" It is a more complex form of technology assessment that is required at the low-income settings. As Kara says, they might have one health economist in the whole country. How do you do that?

Q26 Sir Peter Luff: In a sense, that leads on nicely to my next question about the complexity of health systems. How well do you think DFID—and to an extent NICE International, but primarily DFID—understand the complexity of the health systems they are dealing with in the developing world?

Dr Evans: I think DFID does very well, especially the people in the countries because they are facing it every day. Like Andrew, I met with the regional DFID health advisers for Africa not long back. They have very much got their fingers on the pulse. NICE International have grown up in the British system, and they are, to some extent, having to

learn the complexities of particularly the low-income areas where they have not worked very much.

Q27 Sir Peter Luff: But you all agree about the importance of good governance. That is a truism in this area.

Professor Hanson: Absolutely.

Q28 Sir Peter Luff: Health is also inevitably a very political world, in any society. So, there are real tensions for DFID in terms of ensuring good governance and justifying to British taxpayers that its money is being spent well in those countries. Is there a challenge there for the organisation?

Dr Cassels: Yes, it is a challenge. It brings us back to the results focus, because clearly to communicate to an audience in this country the importance of development, it nearly always has to be phrased in terms of better health outcomes: more lives being saved and so forth, and interventions being delivered. But at the same time, there is the potential to communicate more clearly about the influence of DFID on building up other countries' health systems. The things that people worry about in this country are waiting times, where you live, and how much you have to pay for health, or whether we have to pay for health. All of those things concern all of us. These are issues worldwide, and the work that development agencies like DFID do in terms of helping build up other countries' health systems so that they can improve mortality is something that could be spoken more about.

Professor Hanson: The challenge becomes one of measurement and one of attribution. We are often worried that health system improvement is too difficult to achieve. That just challenges us to find better indicators—to think, for example, how we can use these universal health coverage indicators as measures of health system effectiveness, and thereby to demonstrate how the investments of bilaterals like DFID and other agencies are contributing towards this health system strengthening. We should not shy away from these indicators.

Q29 Sir Peter Luff: Are you able to draw from your experience on how receptive individual countries are to suggestions for improving the governance of their health systems from countries like ours? If they are not receptive, what can we do about it?

Dr Evans: They will be receptive in some areas. My department used to be the Department of Health Systems Financing, and about a year ago I was told I was now in the Department of Governance and Financing, and I had to try to understand what governance was. If you take health system governance to mean that a government needs to set the direction for the health sector as a whole, giving the incentives and disincentives for people to move in that direction, and it needs to monitor and evaluate what happens to ensure that the outcomes they wish are achieved, there are a lot of areas where DFID can help countries improve, and that certainly would not be threatening. These include even setting the directions with new national health plans, or reviews of national health plans, and understanding the incentives that drive and encourage the private sector to behave in particular ways that are conducive to good prevention promotion, for example.

Where the complexity arises is in the corruption areas, and in the losses and the resource tracking. Again, with regards to public financial management and with public expenditure reviews, there are tools that DFID has been involved in with the World Bank, for example, to help countries actually see what has happened to the money, where it went, and how much was leaked. So there are ways that DFID can influence that and has influenced that.

Dr Cassels: My sense is that DFID has an advantage by being present. A lot of the discussions on governance are very sensitive issues. They are difficult issues. It requires trust, continuity, and being able to talk to people, sometimes off the record.

Q30 Sir Peter Luff: So, informality is a strength here.

Dr Cassels: Informality and presence. The global funds, for example, that operate offshore are dependent on a visit every now and again. If they have a role in governance, it is just through the monitoring of indicators that they have selected for their particular programmes. Whereas if you are actually in the country and involved day-to-day with the ministry of finance and the ministry of health, you know what is going on. You can get a sense of where there is room to improve. Not always do you want to write it all down in your annual report, but if you want to know about what is going on in Government, often the DFID country office is a good place to find out. There is a real strength to be built on there.

Q31 Jeremy Lefroy: Just a very brief question: we have been concentrating on governance and financing. The Francis Report has shone a very bright light on culture in the NHS in the UK. I wonder if DFID is doing any work on the culture and quality of care, as well as on finance and governance and these perhaps more arid issues.

Professor Hanson: Do you mean organisational culture?

Jeremy Lefroy: Organisational culture and the real culture of caring for people within the health system, which is so essential and is really the bedrock.

Professor Hanson: Within our research programmes, we have a governance element that also looks at what we call the micro-practices of governance—so, what happens at the level of the frontline health worker? We particularly focus on management, because many people end up in management roles from clinical roles. That clinical management at the coalface where services are delivered is really important. One of the things that we have been looking at with our DFID funding is ways to strengthen local leadership and local management, which is one way of getting at some of these issues around culture and care provision.

Dr Cassels: Nothing to add on that.

Dr Evans: I do not know what DFID does. I know that the Department of Health has been a big player in trying to work with the WHO on improving quality of care in a lot of countries in the past, and continues. I do not know what role DFID plays.

Q32 Chair: I am fresh back from visiting Sierra Leone and Liberia, where DFID definitely is engaged in trying to strengthen health systems. Interestingly enough, in Sierra Leone there was a recognition that they had created a network, but there were questions about quality. In Liberia there were measurable outcomes, certainly in certain sectors, and probably a leadership in evidence that was stronger. How do you actually measure those kinds of things? In Liberia, they were asking how far you had to travel to get access to it. They did not actually ask what the quality of what you got was, but they had other indicators that were possibly measuring that. How do you ensure that, when you set those kinds of measurements, you do not do exactly what you are complaining about in the vertical ones, which is to forget that it will displace something else?

Professor Hanson: There is really no easy answer to that, because one of the criticisms of these first-generation resource-based financing programmes was that they concentrated on quantity and insufficiently on quality. Bringing in measures of quality, which exist—qualitative care can be measured and assessed—but whenever you attach hard financial incentives to a limited number of outcomes that is what you get.

Q33 Chair: That makes Jeremy Lefroy's point about waffle. One of the things about vertical targets is you can measure them, so you can say you have done it, but they displace other things. If you are going to make strengthening health systems a significant objective, you have to have some parameters by which you can measure them.

Dr Cassels: Those parameters exist. There is a good body of work for clearly measuring hard-edged indicators on health systems performance. It does not have to start from scratch; it is there.

Q34 Chair: If you can point us to any of those, that would be helpful.

Dr Cassels: We can do.

Dr Evans: To pick one, I would also go back to what I answered before to Fiona that countries will identify where their major disease priorities are. In those, there is usually a set of interventions that you want people to get. Did the woman who delivered deliver in the presence of a skilled birth attendant? Did the kids get basic immunisation? Increasingly, is a person with Type 2 diabetes controlled?

Chair: The measurements should be bespoke, in other words, to the countries' needs.

Dr Evans: Right, but there is a set of coverage indicators that tells you how well the health system is doing in ensuring that people get what they need. Yes, every country would still monitor the number of health workers it has and their availability of medicines but, in the end, if they get the health services that they need that tells you if the health system is doing its job.

Chair: Thank you very much indeed for coming in. That has been extremely helpful, and we kept almost within time, so thank you for that too.

Examination of Witnesses

Witnesses: **Dr Julian Lob-Levyt CBE**, Senior Vice President, International, DAI, former CEO, GAVI Alliance, and former Chief Health Adviser, DFID, **Lord Crisp KCB**, and **Simon Wright**, Head of Child Survival, Save the Children UK, on behalf of Action for Global Health, gave evidence.

Q35 Chair: Good morning, thank you and welcome. I am afraid we are probably going to have to finish at 12 o'clock and I will have to vacate the Chair slightly before that. Jeremy Lefroy is going to take over, so again could I ask you to please answer the questions, but be as quick as you can and we will get as much ground as we can covered? Again, for the record, I wondered if you could introduce yourselves.

Simon Wright: I am Simon Wright. I am Head of Child Survival at Save the Children, and am speaking on behalf of the Action for Global Health network, which is UK NGOs working on health.

Lord Crisp: Nigel Crisp. I am an independent member of the House of Lords. I used to run the NHS in England and was Permanent Secretary of the Department of Health.

Dr Lob-Levyt: I am Julian Lob-Levyt. I have spent most of my professional career working in health and development, including as the Chief Executive of GAVI, as the former Chief Health Adviser in DFID, and most recently with DAI, a broader development company.

Q36 Chair: Thank you. I suppose we need to get straight to the key point: to what extent are health systems central to development? That is a key point. We have all our central indicators, but to what extent is that a major priority and to what extent do you think DFID'S approach to that is clear and strategic? Who is going to go with that one?

Lord Crisp: May I start? Perhaps I should have said in my introduction I spend most of my time working in Africa and India these days, so I have some knowledge of what we are talking about here. I think it is fantastically important that health systems are part and underpinning everything that DFID does and needs to. Particularly in a world where we are moving towards non-communicable diseases as being the big problems for the future, we need to understand how the whole system can work together to deal with those sets of problems. They are not discrete things, like dealing with eye care or something of that sort, and also, as your previous discussion has said, health systems are fantastically important in terms of delivering both quality and efficiency.

Here I will just make a very quick point that, where I come from, this point of health systems strengthening is really about how you make the system work effectively. It is not so much about the building blocks. There are five quick things I would say: firstly, it is about things like governance and accountability, which we discussed, and about things like NHS evidence and NICE—the things that make the system work. It is fundamentally about the people. I hope I have a chance to say a bit more about human resources. It is also about systems involving patients and the communities. These are not things that are done to people; you need to be taking that aspect into account. It also of course has to be culturally relevant and not make the mistakes we have made in the West. Also, health systems are messy. Some of the discussion about health systems makes it sound as if you

can create a perfect system and, actually, the reality is that you can do things that will start to improve the systems that you have. What you need to do at different times is different.

Simon Wright: We are very proud of where the UK is in its aid work, globally. We reached 0.7% last year. We have also reached, within that, a target that we support, which is 0.1% of GNI being spent on health ODAs. Those are very important things for Britain. Of course, you have heard in the previous session as well about the very many important things that DFID is doing.

For us, the reason for keeping a health systems focus and why this Inquiry is so welcome is that you also have to look at issues like equity. Yes, we may be achieving good results with aid money, but is it helping to build more equitable systems? You need to look at long-term sustainability as well. Of course, we know that health is an area where donors have played a particular part. It is particularly welcome when it has come in, but is it helping to leave a transformed and strengthened health system, which is able to build on those gains? If it is not done in the right way, there is a risk that what it does is weakens that health system and draws staff out from general services into working on whatever particular donor priorities are at that time. That has to be a constant question, which is why it is a very relevant question to look at how DFID is championing building these sustainable health systems, both at national level and especially—an issue that I look at—at global level.

Q37 Chair: Could I add in the question: is DFID still a leader in this field? Do you think it is a world leader in health systems and are there particular things that they should be doing or you would like to see them doing that they are not?

Dr Lob-Levyt: I agree with your first question that health systems should be central. More attention should be paid to them and work in that area is generally under-funded as a result of more disease-specific initiatives, even though they may have been welcome in the past. DFID should and could play a more significant role in that.

Like the last panel, I would agree that, in some countries, they have been quite effective in advocating and working with others to look at those more fundamental challenges. At the global level, DFID has become somewhat weaker, but partly because it has been more fragmented in the way it is both internally organised and the way it presents its views in those very different fora, which sometimes are not very consistently advocated across. As Andrew was saying earlier, that is a very key role for DFID as a major bilateral—its international influencing role of those agendas and where things are going. A little window has opened to paying more attention to health systems and I would certainly encourage DFID to re-seize that opportunity.

Chair: Maybe we can tease more of that out in the next session.

Q38 Mr McCann: Good morning, gentlemen. Can I ask whether DFID's focus on immediate results has been at the expense of investing in health systems strengthening? Secondly, would you perhaps outline the pros and cons of using frameworks such as the World Health Organization's six building blocks? Do you think DFID should use that system?

Simon Wright: If I could say first of all, one of the concerns we have is that we feel that we have lost DFID as a global, very powerful voice keeping other donors to keep a focus on building health systems, organising their aid effectively, making sure that the principles of aid effectiveness are being followed in each country. In the global debate that is going on at the moment, particularly around universal health coverage—this model that the World Health Organisation and the World Bank have adopted as their top priority—it is quite noticeable, and I hear back from developing country governments as much as anybody else saying, "Why do we not hear from the UK on this? You have an NHS. You have this model, but we do not hear you talking about it much."

Ironically we have a situation where the US Government, because of the reforms they have done to their health service, is very keen to champion universal health coverage globally, and the UK Government we are not hearing from so much. That change has definitely happened.

We know when Andrew Mitchell came in that we saw a much stronger emphasis on how we show effective results from the spending of British aid money. They are important questions, especially at a time when aid is under attack. It is very important to be able to show demonstrable outcomes. We would not disagree with that at all. It has been incredibly important. If that is the risk, has it been at the expense of the more general influencing of countries to try to build the sustainable health systems that are going to take up this responsibility when aid money stops, which have to do the topics that have not become donor priorities. Donors choose particular topics that they want to have an impact on; governments need to plug those gaps by funding the other bits of work. That only happens if they are able to build a properly financed, properly staffed health system, which is taking on the responsibility of providing essential healthcare to the whole population. That seems to have been weaker.

There are definitely good examples, and a lot of DFID staff at all levels subscribe strongly to the same sorts of principles that I am talking about. DFID staff are the world leaders in that and often have been. What we are not hearing is that it is a top priority coming from DFID. A number of international fora—the World Health Assembly, UN General Assemblies, the Third Global Forum on Human Resources for Health last year—were all great opportunities where we would normally have expected the UK Government to be there and very visible, but we have not seen them.

Lord Crisp: Very simply, I agree with those points. Actually, if you are going for specific targets or short-term issues it should be done against the context of the bigger picture; otherwise it can be self-destructive. I suspect that there are examples of both that being done well and not being done well from DFID's point of view. I also think there is the second point that Simon's made, which is the potential better relationship between DFID and the NHS, using the NHS and using some of our knowledge of health systems more effectively, and the whole debate about universal health coverage, particularly on things like quality.

Dr Lob-Levyt: I completely agree. Short-term results have driven the way health is being delivered at the expense of broader longer-term health system building. You can get around that with some of the more sophisticated indicators that could be used. DFID would hold some of those global funds accountable whilst at the same time delivering results, ensuring at least that they are doing no harm to health systems, but also actively

contributing to broader health system delivery. That would be a concrete thing that could be done.

Q39 Mr McCann: You move on to the second element of my question, because obviously when we visit in country one of the things that we are very keen to see is sustainability. The question that we always ask is: when we leave, what are we leaving behind? Is it all going to collapse behind us? This is really getting to the heart of the matter. In the last panel, I mentioned the different percentages that have been suggested that DFID actually spends on health strengthening. In order that we can make sure that the Department is accountable for the money it spends and it is doing what it says it is doing, what changes would you make to make it easier to hold DFID to account for how their health resources are allocated?

Simon Wright: As part of the preparation for this, a number of organisations did some looking into how we can track DFID's spending on health systems and it is quite hard; there is a coding for OECD reporting on health system spending that is pure health system spending. Save the Children had a look at it. We came up with 21%; I think a different organisation came up with a bit lower, around 14%. We do not know exactly, but we ought to be able to get from that to pure health system spending.

What we will never know is, of the spending in other categories, how much of that is health system strengthening. That needs to be investigated much more clearly to have good data, because what you call health system strengthening can be a huge variety of activities as well. Yes, if you decide to support some work, such as the bed net distribution that Jeremy Lefroy was speaking about, then you may pay the health service staff to be involved in that activity for a period. Do you count that as health system strengthening or might you count that as potentially taking them away from their everyday work by delivering on one particular priority for a period. We do need some indicators.

DFID has a results framework, which it has issued, which does not have any system indicators; it has outcome indicators and those are very important, but many of those you cannot see within a very short timeframe of two or three-year aid projects, so you will also want to see some system indicators in there. We would encourage DFID to start using some of those as well as part of a broader health strategy to identify some measurable and accountable indicators for its work in terms of trying to build more strengthened health systems. Of course, you would use the building blocks or the WHO models for indicators for health systems strength.

Lord Crisp: The point I was going to make on this was to what extent the country itself is assessing that it has had its system strengthened. It seems to me that is where you might want to start, rather than with the inputs from DFID. The question of exactly what indicators you would use there would obviously need to be worked through, but I do not see why, in principle, they should not be particularly different from the way in which you measure health systems in rich countries. There has been a recent assessment, as you will know, of 11 of the richest countries in the world's health systems, and they are about things like equity of access; they are about what people pay; they are about some very high-level results and so on. There seems to be no reason why one should not be using the same sort of indicators as you would be using.

I take Simon's point that they may be longer-term but, even so, that is the trajectory they should be on and Governments anyway should have some kind of notion of what they are trying to do. It seems to me that would be a much more effective way to pick up on this and also to start to get people to focus more on the fact that, whenever you do anything, you affect the rest of the system. You have to be thinking in systems terms.

The WHO building blocks are fine but, actually, building blocks could be put together in such a way that they turn out a lousy system. The key, right at the beginning, is that how the system works is really important, not whether you have good particular bits, but how the whole thing works together.

Dr Lob-Levyt: Could I disagree with Nigel on one particular point here? I agree with everything that both the folks here have said, but this assumption that least developing countries' health systems are so fundamentally different from richer countries' health systems I really would question. The pace of change now that is occurring in sub-Saharan Africa and elsewhere, the people who I meet and talk with, these are highly sophisticated people. There is strength in depth where there did not used to be. The world has fundamentally changed and it is also changing extremely fast. Certainly from my conversations with ministers of health and others, they want access to the best international expertise and there is not an assumption that they want a second-best health service. This goes for some of the poorest countries. I actually think we ought to reassess this assumption that they need to be treated in some way differently. There is a lot to learn and a lot that can be shared with the National Health Service. More could be done in that area.

Lord Crisp: That is what I said, actually. You misunderstood. I said: why should they not be judged in the same way? Why should they not judge their health systems in the same way as we judge ours?

Q40 Mr McCann: Another supplementary question: would you agree with the statement then that, in terms of how we do that work, we have to ensure that the balance between outcomes and the balance between systems strengthening are blended to ensure that one does not eclipse the other? Would that be a statement that everybody would agree with?

Dr Lob-Levyt: As the last panel said, it is about, with a particular state of development of a country, with its particular level of financing, what the health outcomes or the health services are that should be delivered. What is the most effective integrated public and private, primary and secondary, system that can deliver that to the population?

Q41 Sir Tony Cunningham: DFID channels a large share of its health spending through multilaterals. What is the impact of this on DFID's accountability for its health system strengthening work, and that includes the World Bank and the EU?

Simon Wright: Of course, it is at one remove. On one level, of course we want more multilateralism, because that is better coordination of aid than necessarily bilateral support based on particular topics, but it does take DFID one step away from accountability for that. That is definitely true.

As the earlier panel said, it depends on the institution. At the moment, the World Bank is very clear on helping countries to build sustainable health systems under the banner of

universal health coverage. Starting to look at how you might measure that, what we mean by that and how we answer the accusations that it is just a fantasy that countries could provide all services instantly to all people, the World Bank is coming back with strong answers saying that, actually, it is about identifying who you cover, what kind of contribution they make and how they make it, which services you provide and how you choose. NICE is a very good model for how you look at the cost-effectiveness of different interventions and decide which you can afford to introduce at which stages. The World Bank is playing a very strong role in that.

I have been involved in the civil society grouping around GAVI. GAVI has had a target from Julian's time really, when he was Chief Executive, for health system strengthening as an activity of GAVI's work. Now, we find it quite hard to track that; it is quite hard to know exactly what impact that has. There has been a lot of debate about how much GAVI is responsible for helping to build a comprehensive health system for all health needs, or how much it is about trying to build an immunisation system for immunisation outcomes. There has definitely been a tension between that.

Our argument has been that, if GAVI is serious about increasing equity of coverage, getting to the poorest, most marginalised communities, and making sure that its services are not just getting to the easiest-to-reach segment of the population but getting to the hardest-to-reach, then you need to have work that is going to build a functioning health system, especially because that is what is going to take on the long-term responsibilities. That is delivering the vaccines, even with GAVI's support. Long term, it has to make sure it gets immunisation to all children, so it depends on the institution. A key question of multilateral aid reviews should be: is this work contributing to building a strengthened comprehensive health system?

Dr Lob-Levyt: It depends on the institution you are looking at. The WHO has highly fragmented funding; different donors and different agencies pick their favourite topics and fund them, and that can significantly distort the priorities that the WHO might want to set.

Sir Tony Cunningham: It is difficult for DFID to track that.

Dr Lob-Levyt: It is difficult. DFID can play a role in looking at where those gaps might be and also working with us to make the WHO's life easier, in some ways. Also for the global funds, whether it is the GAVIs or the Global Fund to Fight AIDS, TB and Malaria, how the donors and the boards choose to fund that has a significant influence. I agree very much with what Andrew said: I think that the framework by which the GAVIs and the global funds work is becoming very narrow indeed on the health systems side. It might be fine if we acknowledge that, but do not pretend it is doing anything broader than just ensuring that its particular interests are being well funded.

Lord Crisp: This makes the point that was made earlier, does it not? Actually, the UK and DFID have got a significant role in influence and still have a significant role in influence. If they were clearer, perhaps, about the priority they are giving to health systems strengthening and some of the key aspects, then they would be better able to influence.

Q42 Sir Tony Cunningham: Second question: what in your view have been the consequences of DFID scaling down budget support?

Simon Wright: It is quite difficult to know exactly what is happening. DFID is going to move away from general budget support, and that goes against many of the principles of how to provide aid in the most effective way, which gets behind national systems, which helps to leave strengthened national systems. There has probably been an increase, we think, in sector budget support, so a move away from general towards ring-fencing aid towards certain sectors, but allowing some flexibility with that.

Actually getting the data is very hard, because what each donor counts as sector budget support can be quite different, in much the same way as we were saying earlier. It is quite hard to know, but it would be my estimate that while it has increased, it probably has not kept pace with the increase in aid overall, because we have seen multilaterals and bilateral aid benefitting more out of those increases.

Generally, budget support is meant to be money that goes to the Government for it to use to support its priorities, of course with agreement on overall outcomes and overall indicators. Those are very important to have in place, because it is not just free money for no purpose; it is meant to get in their own providers and support to assist them. The less we do of budget support and the more project aid we do, the more we are looking for short-term outcomes on very particular topics, the more we are expecting often quite unrealistic change from a two or three-year project and, I fear, the less we leave a strengthened national system behind.

Lord Crisp: I would turn it on its head again, actually. I think that is absolutely true, but maybe what DFID should be doing is helping the recipient Government to hold us to account. I think it was mentioned in the earlier panel—forgive me; I arrived slightly late—that there is this problem with all these donors doing different things and operating off their own priorities, and so on. You need a strengthened governance system within the country itself in order be able to steer the donors in a more effective direction.

Therefore, whilst there may be a problem about not giving relatively untied aid, which is what I understand budget support to be, actually if there was some focused aid on helping people with their governance, planning, development and health system strengthening, they would be better able to make sure that the stuff we did and the stuff the French did, if they are doing anything, and the Norwegians, the Americans and so on would be better used.

Q43 Fiona O'Donnell: Could I just quickly ask, Simon, do you think that DFID is rigorous enough in monitoring the impact of its aid that is spend on private sector health providers?

Simon Wright: Recently we have had some evidence that suggests that that is not the case. Actually, when a lot of the outcomes that were talked about are investigated—the transformational outcomes that are expected from the private sector—there is not really any strong evidence for that working. I would say that the evidence suggests that DFID is not strong enough on that and that there is a faith in the role of the private sector, but without necessarily the hard evidence to either justify that focus or for the outcomes.

We all recognise the importance of the private sector: of course you want a vibrant private sector for employment, for commercial, for the economy in a country. The private sector is always involved, to some extent, in the provision of services within health as well. We

hear a lot, and we hear it from all governments—it is not just from DFID; we hear it from many international institutions—around, "Let's look to the private sector for solutions". Actually, the private sector is good at spending our money; it does not generate our money. It does not find any more from new sources to put into health services. It is a way of us spending money, which is raised from our own pockets of course or the pockets of citizens of countries. We do need to be asking some very tough questions about when it is appropriate to use the private sector and when that is a distraction.

If you want to build health services, the evidence suggests that public health services, publically funded through mandatory contributions, which the whole population contributes to, and then organised under government stewardship, are the way of delivering a fair healthcare system. You might have private providers within that, as long as it is stewarded strongly from Government. There are a lot of moves towards and lots of championing of different community-based health insurance, private health insurance models, which are seen as voluntary ways that maybe people might contribute more. All the evidence is they may work for a small segment of the population that might use those, but they do not build more equity and they do not build universal systems.

Q44 Sir Tony Cunningham: Julian, do you have any comments to make on my final question?

Dr Lob-Levyt: On the private sector?

Sir Tony Cunningham: No, on scaling down budget support.

Dr Lob-Levyt: The evidence that we have heard is that budget support has not led to governments putting more of their own resources into the social sectors and health in particular, and that is a real concern. When you talk to ministers of finance in developing countries, they are pretty clear; they say, "The donors will pick up the health budgets. I am going to focus my resources elsewhere." We have to move beyond that.

Q45 Jeremy Lefroy: If I am a parent in a developing country, the thing that matters to me most is that my child can get vaccinated, and my child has access to things like ACTs, paediatric ampicillin and the ability to get tested very quickly. All of these things have been delivered by the Global Fund through things like the Malaria Consortium or other partners that they work with. What really concerns me is that a move back towards health system strengthening, which I entirely support, will run the risk of taking our eye off this incredibly important ball, which is so vital to everybody, anywhere in developing countries.

I think at least two of you have said that DFID is no longer exercising this kind of leadership role. I want to drill down a little bit in health system strengthening. I want to drill down a little bit and ask: please can you give me some examples in specific countries—I am not talking about the generalities, but specific countries—where DFID previously was very much engaged in health system strengthening where it is not now, because I want some evidence of the fact that you are saying that they are concentrating less.

Simon Wright: It is a good challenge and I think we have some, but could probably find some more for you and provide them in written evidence. There are countries like Liberia, which you have just visited, where the UK Government played a key role in getting

Liberia to look at its health system and how it is functioning, especially the removal of user fees and the decision to provide healthcare free at the point of use.

Sir Tony Cunningham: Which has made a huge difference.

Simon Wright: Yes, absolutely, and has transformed the relationship between Government and their citizens around healthcare access. It goes to all of the concerns that you were expressing around if the family knows when a child is in pain or has something wrong with them, but they cannot tell what it is, or they need to make sure the child is vaccinated or protected, is the health service there and functioning, and can they go to it? All the evidence was that cash payments meant that that family might need the care, but they did not go forward for it, because they knew they would not prioritise that with the cash that they had.

Recently, we know that Liberia itself is considering reintroducing fees for certain services, so it is considering reversing that principle. Which services? It is not saying necessarily it would be the most essential primary care services; maybe it is looking at other things, but we have heard—and Mary Macleod, one of your colleagues, came with us to Liberia, where she met the health minister, Walter Gwenigale, where he was saying, "We need DFID's help. DFID has been a champion in this and DFID has been helping us to make sure that we have free healthcare in Liberia." DFID is now considering at the moment whether to continue its support to the health sector in Liberia, or whether it decides not to focus on health in that country.

It is not just the cash support; it is actually the influence that that cash support has given it that we fear is missing. The question we have raised a few times, particularly last year with the Secretary of State, has been whether Britain is going to carry on being a champion of building the kind of health system that, based on the evidence, is what can provide those services. We are not hearing that back at the moment from the Secretary of State.

Chair: The agreement was it was up to Liberia to build in the sustainability, but they have not done it. Part of the reason they have not done it is that the minister of finance has decided, precisely as Julian said, to spend the money elsewhere. DFID is saying we have been conned into extending something, when there was a clear understanding.

Simon Wright: That has been the condition in Sierra Leone as well.

Jeremy Lefroy: Something was specifically designed that was then spent on other things. That is not DFID's fault and that is not DFID's decision.

Simon Wright: True. We heard from the health minister that he would find support, direction and encouragement from DFID around continuing with the free healthcare initiative to be vital for its continuation, but I take your point on those other factors.

Dr Lob-Levyt: It is not just DFID; it is the context that DFID works in. To assume that DFID can fix all of this now, it is that influencing role in the country and more broadly. Let me give you a specific example of a country that I know reasonably well, which is Rwanda, and how that changed. When I first visited Rwanda some years ago, whilst I was with GAVI, visiting one of their district health services, I was very struck by a chat to a woman who had come up and brought her baby, who had a rash, to the clinic. She was

HIV-positive. She was there to pick up her medication. She wanted to take her child to be checked up; her immunisation was out of date, but that part of the service, funded separately, was not open. She had already walked 15 miles to get there. She also wanted to pick up her husband's TB drugs, but that part of the service was not open. That is just complete nonsense, and that was a direct consequence of the separate fund streams by donors at that time.

Visiting later, more recently, with a very strong minister of health, who said, "This is complete nonsense", she was very adept at manipulating the donors into ensuring that services were integrated. It is the same group of health workers so that, if a mother turns up, she can get her kid immunised; she can pick up her HIV drugs and pick up her husband's TB drugs. That is what we should be aiming for.

Q46 Jeremy Lefroy: I entirely agree, but the narrative is that DFID is moving away from such things. The Liberian example is a partial example and we will look at the decision potentially to move funding from the Health Pooled Fund to WASH, but you could argue that WASH is an extremely important part of public health, so it is similar. What I am looking for is clear evidence of this narrative of DFID not engaging at country level. I accept that there may be some things globally. We have all said that countries are individual; they have to make their own decisions, so it is at individual countries that it counts. I want to see clear evidence that there are programmes where DFID was engaging five years ago very meticulously with governments locally, and is not doing so anymore, because I have not seen that on the ground myself.

Dr Lob-Levyt: I think you are probably right. That probably is not the case, as you say exactly. It is these large powerful institutions—the GAVIs and the Global Funds—that then descend, where DFID also sits on those boards and should be influencing them to change their behaviour.

Q47 Jeremy Lefroy: We need to get this clear. What we are talking about is that it is at global, WHO-type level where there is the concern, but getting involved bilaterally or even at a local level through multilaterals, DFID is still playing an extremely strong role there. It is very important to differentiate between the two, rather than just saying, "DFID is not engaging in this, full stop."

Dr Lob-Levyt: DFID is playing a positive role from my experience—and I do not know all countries—at that level, but it is challenged in that it is now dealing, as countries are dealing, with a multiple series of initiatives. They are here to stay; they are not going to go away. They deliver results. It is about moving beyond that early stage of short-term results to long-term how we are going to finance and organise their health systems. It is an opportunity to seize. We have been through a useful phase of increasing funding to very important diseases; it is now about trying to get organised and make that more rational, efficient and accountable to the community.

Q48 Jeremy Lefroy: If I can just move on to the importance of community and faith-based organisations in various countries—I am thinking specifically Zambia, where at least 50% of their health facilities are provided by faith-based organisations and are reasonably well-integrated into the Government system—is DFID engaging with them as an

important part of health systems, or does it tend just to work with state-run, nationally run organisations, as opposed to faith-based or community health organisations and facilities?

Simon Wright: On this and your previous question, I would like us to come back to you, and I think we can, with some more national examples, because I think they do exist. It is just with the way that an aid project is shaped, the kinds of outcomes and indicators that are put into that would be quite different. I know from Save the Children, from the work that we did with DFID funding, we are often asked to come up with more outcome indicators within the short term and less that would let us do work that is around influencing the very factors of the health system and how it is going to be sustainable, so I would like to come back on some of that.

In terms of working with NGOs, with faith-based organisations and other non-state actors, the ideal situation is that those are integrated into a state-led health system. That is very important. Actually, the more that you bypass that system and work with other actors directly, the more you undermine that system, the more you reduce people's expectation that their Government is going to be accountable for the delivery of their healthcare. I hear it many times when I go to areas; you hear communities say, "Oh, it's fantastic. We go to the Methodist Hospital", or "We value what Save the Children is doing", or "We value what Sightsavers is providing in this area". You hear all of these things, but that reduces the expectation that governments are actually the ones that should be accountable. Your local councillors, your members of parliament, and your Government are the ones that should answer to their citizens around the provision of healthcare. It must be integrated into the system.

As I said before, using different types of actors I think is very sensible. It makes lots of sense in lots of health systems to try to do that, especially where it is cost-effective, where they have some of the infrastructure there to try to deliver, but it is not a substitute for a functioning system. The Government is going to be the one that takes the step back and says, "Are we covering the whole country? Are we covering all wealth groups? Are we covering all ethnic minorities? Are we providing healthcare in a way that is aware of gender or other areas of discrimination?" We do need to rely on governments to do that.

Again, I am not going to quote some hard national evidence, but I would like to commit to trying to see if we can provide some for you. We would find DFID probably working a little bit more, encouraging the use of non-state actors. My fear would be that, in some cases, you might find examples of where the funding goes directly to those without necessarily being well coordinated by the Government and that is when it is a negative, I would say.

Dr Lob-Levyt: In particular, the Zambian Government does support the church. It is part of the system and it is integrated with it. I do not think internationally NGOs like Save the Children—with apologies—should be running clinics in countries. I think that is a retrograde step. It should be national if at all possible.

Q49 Jeremy Lefroy: Very much accepting that these non-state institutions, whether community, faith or private, should be within an overall framework, one thing that was brought out quite strongly to us during our recent visit was this whole issue of parliamentary accountability. NGOs in particular are very good at bypassing parliamentarians and not engaging at all with the legislators and the people who are supposed to represent their

communities. NGOs often talk about some accountability but, actually, the very people who are supposed to be accountable are the local members of parliament. I wonder whether you would like to say anything about that and whether NGOs need to up their game in terms of working through the local accountability mechanisms, rather than just deciding that they want their badge on every project.

Lord Crisp: May I give you a couple of examples of that? I do agree with that. If I take the example of Zambia, as we are on Zambia, I happen to chair something called the Zambia UK Health Workforce Alliance, which is chaired by myself and the High Commissioner from Zambia to this country. It is precisely about NGOs trying to get their act together. We run conferences twice a year, one in Zambia and one here, and the minister comes from Zambia to talk to the NGOs in this country.

This is just a step in the water; we also run one in Uganda. This is only a step in this direction, but hopefully DFID's new partnership scheme will now start to support these alliances as well. If the Brits at least can get their act together—at the last conference we were at in Lusaka, the permanent secretary who was chairing it with me said, "If you foreigners got your act together, you would double my budget. As it is, you add 20%." That is a slightly different point from your one about accountability, but British organisations in Zambia and Uganda that join these alliances commit themselves to working within the framework. I think we could do more with that. I actually think it is even more important that Zambia and Uganda assert themselves in this area, rather than waiting for us to do it but, at the moment, we should be pushing down those lines. DFID has been broadly encouraging of us doing that.

Q50 Chair: Lord Crisp, I know you are keen on community health workers and we have seen them in action, particularly in Ethiopia, but to some extent elsewhere. That seems to bring together both prevention, by definition, health education and access, because you have a single channel. Do you think there is more scope for developing that as a system, and do you think DFID should perhaps give it a higher priority?

Lord Crisp: Thank you, yes. Let me be clear: community health workers are part of a system.

Chair: I appreciate they cannot do everything.

Lord Crisp: When I have talked to ministers of health about this, they have actually said to us, "Look, we can broadly train our own community health workers and actually most of our mid-level workers. Where we really need your help is in the specialities." In Zambia, for example, we support specialist training in five areas, which is not done within the country. I think DFID could do an enormous amount more to do this, because this is the health system. Other aspects of it are important, but actually having people on the ground is the greatest shortage in Africa. I could say more about this and maybe this might be something I might just drop you a note about, because I am conscious that you are conscious of the time.

Q51 Chair: The only other point I was going to say was just what you have just said. It will vary from country to country, and the priorities will vary, but are we sure that we inform ourselves enough by what works on the ground, when we are doing that kind of thing?

I take your point that, as indeed in Ethiopia, you train your own community health workers, but you need to know what the rest of the system is for that to work.

Lord Crisp: Exactly right. In Ethiopia, the particular problem has been that the higher professionals have not accepted the community health workers. I think we need to do that, but I also think this is an area where the UK can do a lot more in terms of using our experience and expertise. I have talked to a lot of health ministers, as part of running a programme for new health ministers at Harvard, and one of the biggest things they want is education and training of health workers from the UK. DFID does a certain amount of that, but we could do a lot more. We have benefited, obviously, from skilled health workers coming to our country from other countries. We could do a lot more, it seems to me, to support the training and education of health workers, in their own countries, using our people. There is fantastic enthusiasm for it.

Chair: They tend not to leave the country.

Lord Crisp: It is cheaper and, candidly for some of our people, this is two-way. It is a point that both of us were making earlier: this is one world. We are in it together and our people can learn from working in other countries, just as other people's people can learn from working with us.

Dr Lob-Levyt: It is something that needs to be approached fairly systematically as well. If you look historically over time, community health workers have been seen as magic bullets for under-funded and poor-performing health services. It needs quite a good level of integration and sophistication, linking into that system of secondary referral to give credibility to make it work. Ethiopia and others are making some progress and we are learning lessons from it, but it is certainly not a magic bullet. There is a real risk that some institutions are going to rush in to funding it as yet another initiative.

Simon Wright: There is a risk that community health workers are being asked to deliver more and more services, particularly with aid money coming in from donors, which involves training community health workers in a new technique or a new condition or a new piece of work. These are people who, by the nature of the training, by the nature of the amount they are paid, are not going to be able to take on huge amounts of responsibility. They are right when they are used well, but there is a danger that too much emphasis is put on them.

We celebrate the fall in the under-five mortality rate, which has been achieved, and a lot of that has been achieved by vaccination, by bed nets—bed nets community health workers have a particular role in—and identifying childhood illnesses and getting children quickly into treatment. Where we are not seeing a fall is in the new-born mortality rate—deaths within the first 28 days. Generally that is because what you need there is a trained health worker who can support a woman during labour and who can act quickly if there are complications during labour. That is not something a community health worker can do. A health system actually needs to build that type of health worker, and get them in place, in reach of every birth. We must look for the short-term solutions—the quick wins—but we must also build the long-term change as well. There is a danger that aid money has a pressure towards the quick wins.

Lord Crisp: I would not over-estimate that. I think more and more people understand that this is a system and there is a lot of evidence now about what works. The same is true for

our country, where nurses do prescriptions now, which they did not do before. People have changed, and you must have a much more flexible workforce. That is the general point that is being made.

Chair: People recognise in Liberia that community health workers are not midwives.

Q52 Fiona O'Donnell: Julian and Nigel, you have both said that you are enthusiastic about better cooperation between the NHS here and health services in developing countries, but we have been told there is some resistance within the NHS, with people concerned about their career progression and services concerned about losing staff. I just wondered if you wanted to take the opportunity just now to make a pitch, because there is only £10 million just now spent on this scheme in the UK. How would you make the case for a bigger budget and how would you tackle those barriers?

Lord Crisp: Are you talking about the Partnership Fund?

Fiona O'Donnell: Yes.

Lord Crisp: Internally, what you will find—and I have talked to lots of people around this—is that individual nations may be enthusiastic, but they may find there are some practical barriers, in some cases. People can get around that and the enthusiasts do get around that. There is a fantastic amount that is happening.

One of the big keys here, though, is to make linkages with health education in England. I had some doctors come to see me yesterday from Bristol. In GP training, you can take a year out. Do you go to Australia and have a good time or do you go and take a job in South Africa or in Zambia, in the government system for a year, where you are making a contribution but you are also gaining hugely from it? The third year in GP training, for example, is what they were specifically talking to me about. There is an organisation that facilitates that happening, which makes sure that you can get yourself on the register, you get insurance and all this kind of stuff. You get payment from the South African Government at the South African rate. The argument we are now putting to Health Education England and others is that a small facilitating amount of money would allow that to become systematic, so that of the 6,000 doctors who go through student training every year, a proportion of them may be able to do some work within a government-funded job somewhere, on a systematic basis, and contribute.

Q53 Fiona O'Donnell: That is not just happening within NHS England though. Is it also happening with the devolved health systems?

Lord Crisp: To be honest, Wales is ahead of this. The Scots, I think, also do something, but I was thinking NHS England; you are quite right. It is happening in other countries too. There is a proposal in front of USAID that doctors doing this should be let off a proportion of their student loan, as an incentive. That is something again we will be proposing, following my meeting yesterday, to DFID, because actually there is a potential great win-win here. We have people who understand health better because, if you are a doctor in London, a GP, the world walks in your door. You are a gate in global health. I think there is a lot more that can be done about that to make it systematic, and I think that is probably the level where it is easiest to do it. I would appreciate more money for the partnership schemes, but that would probably the level I would give priority to.

Dr Lob-Levyt: I have three brief comments about that. One is that West Bengal in India is already buying the services of the Royal College of General Practitioners for developing diploma programmes, paying for them itself. You are going to see more of that. Linking professional groups internationally in this way is something that should be encouraged and has a value.

I also think that with the joint working of DFID and the Department of Health on global issues, I have not been in it recently, but it was always difficult and quite a strain, particularly over the WHO. The Department of Health leads the relationship with the WHO, and DFID has different sets of priorities and agendas. That was not always, in my experience when I was Chief Adviser, to be honest, an easy experience. It was nothing to do with Nigel; I think it was before Nigel's time.

Lord Crisp: I understand what you are saying.

Dr Lob-Levyt: That is one where the two Departments could work better together. I also think, as we were saying earlier, there are a lot of other kinds of expertise in the National Health Service. We also discussed NICE, but I think there is expertise in management and organisational management of services, which is now globally appropriate to many developing countries. How do we do that? Do we now encourage some of that skill set to come and sit in DFID for a while to help them develop their programmes, interactions and relationships with the Department of Health? Do we need those kinds of skills at running services embedded within DFID itself and into its programmes? That needs to be funded. DFID has a reasonable budget; it could decide to fund that and decide to put a certain amount of funding into those kinds of innovative and new relationships.

Simon Wright: The only thing I would add to it is that I think that there is a lot of expertise in the NHS that is not necessarily doctors and nurses, although we have a key role in helping to train training institutions in those countries—that is the question: to make sure it is sustainable—but around health financing. Britain has the experience of funding a universal health care system, set up in a time of austerity, when there was not a huge amount of funding, and making quite tough decisions about which services it provided and when and to whom. That expertise would be of huge use to countries as they try to both raise funding and organise funding for health systems.

Lord Crisp: This was my point about understanding how health systems work. Engaging people who have run systems in those sorts of questions is really quite important.

Q54 Sir Tony Cunningham: I just wonder if DFID's existing approach to health equips it to tackle major emerging issues, such as non-communicable diseases, ageing populations, the growth of urban slums and issues like this.

Simon Wright: At the risk of repeating things from earlier, that is the reason why you need a functioning health system. It is clear that certain issues get to the top of the donor agenda, and then there is money for those, for a period. Sometimes those priorities change. One big issue with the Global Fund is that it is providing antiretrovirals to quite a large number of people that are keeping them alive. That is an open-needed commitment that is needed, and yet donors are talking less and less about HIV, for example, and talking more about other topics. Therefore, you have to try to make sure that, whatever the work is, it leaves a strengthened, comprehensive system there.

NCDs in particular are generally not addressed through quick wins, unlike infectious diseases, and so they do need a long-term functioning health system, which is going to manage diabetes, support healthier behaviours and is going to be able to deal with chronic conditions over the long term. The risk is that, if a health service is judging by quick results, if we have looked at certain disease priorities but not at others, then we have structured our aid money and, therefore, influenced health systems to deliver on those and not to be ready to deliver on some of the long-term NCD issues.

Dr Lob-Levyt: There is a very strong argument that, having sustainable health systems, you will see that decline in infectious diseases. There is a necessity—you could argue about that—for vertical funding. You are now seeing that double whammy of diabetes, hypertension and chronic disease coming in, and in many developing countries that is actually where the burden of disease now lies. You need this more integrated and better platform to help deliver those emerging priorities, which are not funded by donors at the moment. That is where the challenge for ministers of health in developing countries is. If you talk to them and say, "These are our priorities now but we are now getting no funding for this, and we are being dragged to these separate rather old priorities", they are still necessary to fund but in decline compared to this double whammy that they now face.

Q55 Fiona O'Donnell: On the Millennium Development Goals, what do you think they have contributed towards progress in terms of child health? I know that, Simon, you mentioned the particular shortfall in new-born mortality. What do you think are the best indicators and targets for health going forward to post-2015? I just wondered if you would comment generally as well on universal health and what that actually means, because it could mean different things in different countries and in different settings. Is it going to rely not on the model you have spoken about, Simon, but on private insurance? Is it actually the best way to focus going forward?

Lord Crisp: Maybe I can start with two very quick perspectives. I happen to co-chair with Meg Hillier the All-Party Parliamentary Group on Global Health. We got a group of other All-Party Groups together to discuss this, and the single thing we came back to links those two points, which is what is happening to the poorest 10% to 15% in the country. That will be different in different countries, to pick up your point. There is a famous saying from Agnes Binagwaho, the minister of health from Rwanda, which is basically: if you get it right for the poor, you are going to get it right for everybody else. I think that is right and I think that is where we should be looking in any future goals. It is what is happening with the disabled and the poorest people who end up in that bottom 15%.

Therefore, with another hat on, at Sightsavers, which I happen to chair, one of the things we have been arguing very strongly for is the disaggregation of data at that level, so that the goal is not the universal one, but it is actually if we are sure about what is happening about disabled people. Are we sure what is happening about women? Are we sure what is happening about different ethnic groups in communities? It is a focus on the poorest and the most disadvantaged in the community, which will be different in different countries.

Frankly, going back to the theme that I keep hammering, Britain is part of the globe. When we are talking about this, we should be thinking of such targets applying to ourselves as well.

Fiona O'Donnell: Yes, exactly—inequality of health outcomes here too.

Dr Lob-Levyt: The Millennium Development Goals did powerfully shape agendas in health. There is no question about the 2015 goals. They helped drive a lot of the funding that resulted behind that. As we heard from the earlier panel, you have a slightly broader and more inclusive, possibly sustainable, agenda, even though health systems may not specifically be mentioned. We also have—and we know from research and other work—a good set of indicators that could be applied country by country, at different stages of development, which would help drive that. That is certainly what we hope DFID will continue to argue for, as we go forward.

It will be captured otherwise by the foundations and others with their specific interests around specific diseases or specific technologies or specific ideas. It may have less value in this very fast-changing world. I personally was very active in advocating for the kinds of goals we had for 2015. On this side, because this world is changing so fast, I think there is going to be less driving of agendas, because capacities and skills are changing. The international connections are changing. Aid dependency is in massive decline. The biggest challenge for DFID in the next five to 10 years is what justifies itself. What is its role? How is it going to shift to this very fast-changing development world?

Simon Wright: I must just add that there are lots of lessons from the MDGs. One is that donor money did get behind some of the identified priorities, particularly HIV and, to an extent, malaria and TB, less perhaps to some of the priorities around child mortality, where aid money actually is more around catalytic change in the country.

As UNICEF has done quite a lot of work on, the big fault with the MDGs was that there was no equity element to the data, so it looked at national averages. If you took a national average and wanted to reduce it, what they have shown is that, in some countries, the indicators have probably hardly changed for the poor. What they have been able to do is make improvements for the wealthier quintiles in the country. The same would be true if we had the data, I am sure, on ethnic minorities.

One of the things we are calling for in the next framework is to say that no target should be regarded as achieved unless it has been achieved in every section of society, both on the wealth quintile and where you can get other data. That would be very important, because I think we would be able to show than the MDGs have not been achieved, even in the countries we celebrate. For the poor, they have not made that much difference. UNICEF has said in that, in some cases, they have even made things worse on some indicators, for the poorest.

The answer to that is of course universal systems. UHC is much maligned and deliberately misunderstood a lot of the time, I think. There is a huge debate about what it is. For me, it is generally around health systems, but it goes a little bit further, because it is political and it is about a Government accepting and speaking to its responsibility to ensure that its whole population can access an essential set of services, and identifying what those are and how they are going to be funded. That is quite revolutionary in many countries, where really a lot of essential healthcare is left to chance.

Fiona O'Donnell: And free at the point of delivery.

Simon Wright: Generally, with UHC, I would argue—and this is the evidence—that the accepted framework is reducing to make sure people either are not pushed into poverty by

the way they have to pay for it—and generally cash pushes people into poverty, so they have to come up with cash—or the accepted framework around UHC is to try to make sure that there is risk pooling. Acceptance of that responsibility is such a political step.

There is some good work the World Bank has done, where they have looked at citizens who understand their countries. Their governments have made a commitment to UHC, and they are now better at holding the governments to account, because they start to have an expectation and you are not leaving it to the chance of whether there is a good, charitable hospital, a faith-based service provided, or whether people have the cash to go to quality healthcare or have to pay cash when it is an emergency to go to very poor private healthcare. Once you take that out and say, "How can you organise your health system?" that is how we will achieve these universal goals and start to reduce inequities.

Fiona O'Donnell: The US is the most developed country in the planet.

Q56 Jeremy Lefroy (in the Chair): Thank you very much. Just one final brief question from me, because I realise colleagues have to go. It seems from your answers that all of you would very much endorse universal health coverage as an overarching post-2015 goal in health, but how would you flesh that out? How much would you flesh it out with subsidiary goals and how do you think it can best be achieved?

Simon Wright: Whether it is going to be a goal seems a little less likely at the moment, but it seems very strong that it will be a target within a health goal. We have recently had some parliamentary answers from the Secretary of State saying that she supports a universal health coverage target, including for increased financial protection, which is very important. We would try to make sure it is based around that.

The indicator work that has been done by the WHO and the World Bank proposes a set of indicators of core services, with some of them picking up the MDG focus, some of them looking at NCDs and some of them looking at other essential primary care. They are looking at this package of indicators of health service coverage, with equity built into it, to judge whether a country is making the right progress towards universal health coverage. As Margaret Chan said, no country has universal health coverage. It is an ideal; it is a set of principles that every country should be working towards. You need to constantly watch what you are doing to make sure you are getting closer to it, but that is what we would like to see: a clear commitment to working towards equitable and universal coverage of key indicators.

Lord Crisp: I would just want to emphasise two things. One is, as has been said, this means a lot of different things. There needs to be a strong component of quality in there and understanding of what it is that you are actually talking about. In terms of not just coverage but quality, you can see this being gamed very easily, if one was not very careful. That is why I would start at country level. I really would start with the point that I made earlier, which is about what is happening with the poorest. Get it right for the poor and you have a chance of getting it right for other people within the country—I absolutely accept the point that has been made about equity there—rather than being too obsessed with trying to get into too much details about what it actually looks like.

The Mutuelle in Rwanda looks very different from the system they are developing in Ghana, and that looks very different from South Africa, where they have the great problem

of that huge amount of private sector stuff that is already there. It is going to be very different. The question and the test are about what is happening for the poorest 10% to 15% in each of those countries.

Dr Lob-Levyt: Universal health coverage does run the risk of previous goals and challenges we had in the past, like health for all by the year 2000, and things like that; it can be read very broadly. Therefore, it is very vulnerable to criticism. Organisations such as DFID could play a very good role in working with the World Bank, the WHO and others in articulating that a lot more clearly than it has been articulated at the moment. What is the message that you want your minister to say? What is it your staff are going to say in-country that crisply categorises what we mean by this? More specifically, taking that to the country level at this stage of economic development, what is a reasonable set of health deliverables that that country should aspire to and what is the route and pace to this universal health goal?

I am a little concerned that it is read very broadly at the moment and means everything to anybody. People can pick and choose what they want from it. If DFID has endorsed it, as it seems to have in its policy paper in July, it needs to articulate more clearly what that means and how it is working with others. Most importantly, how are we going to measure that process? I think it is hard. It is always how you communicate these things. That was the beauty of the MDGs; you could just communicate the malaria, TB and HIV goals. They were easy to communicate to the public at wide, and this is a trickier one. These are smart people and we need smart people to get it right.

Lord Crisp: The strapline when the NHS was invented was, "In place of fear". That is what I think universal health coverage should be: in place of fear. That is why I put the emphasis on the bottom 10% to 15%.

Jeremy Lefroy (in the Chair): Thank you all very much indeed for your time. It has been an extremely useful session.