House of Commons

International Development Committee

Strengthening Health Systems in Developing Countries

Fifth Report of Session 2014–15

Report, together with formal minutes

Ordered by the House of Commons
to be printed 2 September 2014

HC 246
Published on 12 September 2014
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

International Development Committee

The International Development Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Office of the Secretary of State for International Development Committee.

Current membership

Rt Hon Sir Malcolm Bruce MP *(Liberal Democrat, Gordon)* (Chair)
Hugh Bayley MP (*Labour, York Central)*
Fiona Bruce MP *(Conservative, Congleton)*
Sir Tony Cunningham MP (*Labour, Workington)*
Fabian Hamilton MP (*Labour, Leeds North East)*
Pauline Latham OBE MP *(Conservative, Mid Derbyshire)*
Jeremy Lefroy MP *(Conservative, Stafford)*
Sir Peter Luff MP (*Conservative, Mid Worcestershire)*
Mr Michael McCann MP *(Labour, East Kilbride, Strathaven and Lesmahagow)*
Fiona O'Donnell MP (*Labour, East Lothian)*
Chris White MP *(Conservative, Warwick and Leamington)*

The following member was also a member of the committee during the parliament:
Mr Russell Brown MP *(Labour, Dumfries, Galloway)*
Richard Burden MP *(Labour, Birmingham, Northfield)*
Mr James Clappison MP *(Conservative, Hertsmere)*
Mr Sam Gyimah MP *(Conservative, East Surrey)*
Richard Harrington MP *(Conservative, Watford)*
Alison McGovern MP *(Labour, Wirral South)*
Ann McKechin MP *(Labour, Glasgow North)*
Mark Pritchard MP *(Conservative, The Wrekin)*
Anas Sarwar MP *(Labour, Glasgow Central)*

Powers

The committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website at www.parliament.uk/indcom and by The Stationary Office by Order of the House.

Evidence relating to this report is published on the Committee's website at Strengthening health systems in developing countries

Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), Chloe Challender (Senior Adviser), Louise Whitley (Committee Specialist), Adam Mellows-Facer (Committee Specialist) Richard Ratcliffe (Committee Specialist) Anita Fuki (Senior Committee Assistant), Paul Hampson, (Committee Support Assistant) and Hannah Pearce (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the International Development Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 1223; the Committee's email address is indcom@parliament.uk

Contents

Report

Summary

Better health is a basic human right and an end in itself. A healthy population is also essential to development. Recent years have seen some rapid improvements in health partly driven by the Millennium Development Goals and the large international funds set up to accelerate progress towards them. However, these improvements have at times been achieved despite the poor state of health systems in many developing countries. Stronger health systems will be required to ensure efficiency, tackle growing challenges such as non-communicable diseases and progress towards self-sufficiency.

DFID has long had a good reputation for health system strengthening and this is reflected in its own work. But DFID now relies on international partners, which do not all share this reputation, in an increasing number of countries and to manage an ever-greater proportion of its expenditure. We recommend that DFID reviews in each country whether its funding arrangements enable its health systems strengthening objectives to be met.

Assessing the effectiveness and value for money of health system strengthening work by DFID and its international partners is more difficult than it ought to be. Expenditure and performance figures are not published and the research base is inadequate. This must change. We also recommend DFID takes the lead in system governance and finance, and publishes a new strategy on health workforces.

The UK has one of the best health systems in the world, but DFID makes only limited use of it. We call on DFID to work with the NHS in expanding volunteering schemes for doctors and nurses and making more use of NHS finance and management skills.

Finally, we urge DFID to demonstrate global leadership worthy of its health systems expertise. It should be a vocal champion of system strengthening and seek to influence its international partners to prioritise it in their work. It looks likely that universal health coverage will be a target in the global post-2015 development goals, providing a chance to increase international focus on system strengthening. DFID must grasp this opportunity.

1 Introduction

1. The enjoyment of the highest attainable standard of health is an end in itself and, according to the World Health Organization (WHO) constitution, a basic human right.[1] A healthy population is also fundamental to societal development and economic growth.[2] Recent years have seen some rapid improvements in health outcomes in developing countries: malaria incidence and the number of new cases of HIV have each fallen by around one-third since the turn of the century and the global child mortality rate has halved since 1990.[3] Nevertheless, there is widespread concern that many developing country health systems remain weak. The UK Department for International Development (DFID) argues that, though outcomes can be improved rapidly in the short run through disease-specific "vertical" interventions, health system strengthening (HSS)[4] is essential for long-term efficiency, sustainability and, ultimately, a future without aid. [5]

Box 1: Vertical and horizontal

Health interventions that seek to target particular diseases, such as HIV or malaria, or population groups, such as mothers or young children, are sometimes known as "vertical" programmes. They can be crudely distinguished from "horizontal" programmes, which aim to achieve better health outcomes by making improvements across all conditions or population groups, often through strengthening underlying health systems. In reality, many programmes include both vertical and horizontal elements.

2. A global United Nations survey in 2013 found that better healthcare ranked second behind education as the highest public priority. In Africa, improved healthcare was the single most important concern.[6] A good health system delivers high quality services when and where people need them. The public expect a healthy environment, with access to clean water and nutritious food, information about how to stay healthy, preventative care such as immunisation, local access to advice and basic treatment, a system of referral to more specialist care and provision for emergencies. They can reasonably expect such services to be provided regardless of their social background, without resulting in impoverishment and preferably free at the point of use, and taking into account their preferences about their care.[7]

3. We were told that HSS was now of particular importance because the "quick wins" from scaling up vertical interventions in major communicable diseases and child and maternal

1 World Health Organization, *Constitution of the World Health Organization*, October 2006, p1

2 DFID, *Health position paper: delivering health results*, July 2013, pp4-5

3 World Health Organization Factsheet 290, *Millennium Development Goals (MDGs)*, May 2014

4 The World Health Organization defines health systems strengthening as "[i] the process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges; [ii] any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency". See http://www.who.int/healthsystems/hss_glossary/en/.

5 HSS19 [DFID]

6 United Nations, *My World, the United Nations Global survey for a better world: summary of results*, March 2013

7 World Health Organization Factsheet, *Key components of a well-functioning health system*, May 2010

health have largely been exhausted.[8] Furthermore, system strengthening was required to maximise the impact of unprecedented recent investment in areas such as tackling neglected tropical diseases.[9] Other witnesses stressed that HSS was essential to tackling growing and persistent issues such as non-communicable diseases (NCDs), ageing populations, mental health, conflict-affected regions and under-provision in rural areas and urban slums.[10]

4. The devastating ongoing Ebola epidemic in West Africa has served to emphasise the importance of establishing strong health systems. The developing, but impressive, health system we saw on our recent visit to Liberia has been completely overwhelmed and DFID has recently committed extra funds to support health systems in the region.[11] The apparent hesitancy and lack of coordination in the international response suggest that the global health system and emergency plans have failed.[12] We will publish a separate Report on *Recovery and Development in Sierra Leone and Liberia* shortly.[13]

5. DFID has a long-held reputation as a world-leader in HSS, and we heard praise for its current approach.[14] However, concerns were expressed that a target-driven mentality has precluded sufficient focus on HSS and that a lack of information has made evaluating HSS work difficult, especially where DFID funds are channelled through multilaterals.[15] These issues are considered in chapters 2 and 3. In chapter 4, we examine DFID's performance in supporting improvements in important components of health systems such as workforces, governance and system finance. Chapter 5 assesses whether better use of the UK's domestic health expertise could be made in international development. Finally, we heard calls for DFID to show greater global leadership on HSS and we consider these issues in chapter 6.

6. We received a substantial volume of informative written evidence. We also took oral evidence from four panels of HSS experts, including representatives of academia, NGOs, multilateral organisations, the NHS and DFID. We are very grateful to everyone who contributed. Our evidence focused on areas of key concern in what was a broad topic for a short inquiry. This Report does likewise.

8 Q2 [Dr David Evans]

9 HSS40 [UK Coalition against Neglected Tropical Diseases] and HSS37 [Sightsavers]

10 HSS44 [Dr Julian Lob-Levyt], HSS32 [Age International and HelpAge International], HSS14 [Programme for Improving Mental Health Care [PRIME] University of Cape Town, HSS35 [International Committee of the Red Cross], HSS19 [DFID] and HSS45 [Dr David Evans]

11 DFID press release, *Britain to extend assistance to combat Ebola in West Africa*, 18 August 2014

12 Financial Times, 19 August 2014, *MSF criticises global response to Ebola crisis*, by William Wallis

13 International Development Committee, Sixth Report of Session 2014-15, *Recovery and Development in Sierra Leone and Liberia*, forthcoming

14 HSS7 [London School of Hygiene and Tropical Medicine]

15 For example HSS2 [NICE International]. Along with other donors, DFID channels a proportion of aid through international bodies for use in or on behalf of aid recipient countries. These, including large international funds such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, are abbreviated to "multilaterals" in this Report. Aid channelled through multilaterals is regarded as bilateral where DFID specifies the use and destination of the funds

2 DFID's health systems work

Expenditure

7. Almost one-quarter of DFID's total project budget in 2014-15 is allocated to health, making it DFID's largest area of spending.[16] The UK is one of the few donors to have increased official development assistance (ODA) on health as a proportion of gross national income in recent years, reaching the WHO recommendation of 0.1 per cent in 2011.[17] DFID was the third largest donor of ODA for health in 2012, behind only the United States Agency for International Development (USAID) and the Bill and Melinda Gates Foundation.[18]

8. Much of DFID's health expenditure is channelled via international multilateral organisations. DFID's bilateral expenditure (aid to a specific country) on health was £907 million in 2013, while it provided £387 million to the GAVI Alliance (GAVI), £543 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), £53 million to UNITAID and £166 million to the WHO in 2013-14.[19] In total, UK ODA for health is roughly evenly split between multilateral and bilateral channels.[20]

9. DFID estimates that it spent £360 million on supporting health systems and £10 million on health systems research in 2013-14. In total, this accounted for around 34 per cent of total bilateral health spending, excluding core contributions to multilateral agencies. This was slightly lower than the 41 per cent estimated for 2008-09, though expenditure in absolute terms has risen substantially over the period.[21] DFID noted that these figures are likely to be substantial underestimates; programmes primarily focused on one particular disease or population group often have a significant health systems component.[22] Other estimates are lower: Action for Global Health suggested 14 per cent, based on the incomplete data on DFID's Development Tracker website; while Save the Children estimated that 21 per cent goes on direct systems strengthening.[23] Regardless, the actual figure is likely to fall below the WHO recommendation of spending 50 per cent of health international assistance funds on HSS.[24]

16 http://devtracker.dfid.gov.uk/

17 HSS22 [Action for Global Health]

18 OECD statistics, http://stats.oecd.org/, Official Bilateral Commitments (or Gross Disbursements) by Sector.

19 DFID *Annual Report and Accounts 2013-14*, table B.3 and pp100-114

GAVI was previously the Global Alliance for Vaccines and Immunisation

UNITAID was established in 2006 by the governments of Brazil, Chile, France, Norway and the UK as the "International Drug Purchasing Facility". It aims to use "innovative financing to increase funding for greater access to treatments and diagnostics for HIV/AIDS, malaria and tuberculosis in low-income countries". See http://www.unitaid.eu/.

20 HSS29 [Save the Children]

21 HSS19B [DFID]. We were disappointed that DFID was unable to provide the same detail in health expenditure for 2013-14 as it provided for earlier years in that submission, despite publishing its *Annual Report and Accounts* for 2013-14 on 15 July 2014.

22 HSS19 [DFID]

23 HSS22 [Action for Global Health] and HSS29 [Save the Children]

24 World Health Organization, *World Health Report 2006*, p xxiv

10. DFID's support for HSS includes technical assistance to governments and health providers, policy advice via a network of health advisers and direct funding to governments through both general and sector-specific budget support.[25] Financial aid, which includes budget support, has accounted for a decreasing proportion of DFID's bilateral HSS expenditure in recent years: it accounted for 42 per cent in 2012-13, compared with 66 per cent in 2008-09. Over the same period, the proportions used for technical assistance and, in particular, the delivery of bilateral aid through other organisations, have grown. In 2012-13, 36 per cent of DFID's bilateral HSS expenditure was channelled through multilaterals, NGOs or other third-party organisations.[26]

Bilateral programmes

11. DFID has a longstanding reputation as an effective promoter of sustainable investment in health.[27] However, it stands accused of undermining this reputation by focusing on vertical programmes and targeting short-term improvements in health outcomes, to the detriment of health systems.[28] For example, GRM Futures Group International, a consultancy, wrote:

> Over the past five years or so […] DFID has responded to the perceived need for fiscal accountability by promulgating a value for money approach that tends to over value short-term results that are more easily counted and rolled up and under value intangibles that underpin health systems.[29]

NICE International told us that a "target-driven mentality" is "perhaps the greatest obstacle to DFID fulfilling its role in HSS globally", arguing that it resulted in important, but difficult to quantify, elements of HSS such as institutional reform, audit and decision-making processes being "under-valued and under-funded".[30]

12. DFID disputed this analysis, pointing to independent reviews which found that it had generally avoided a narrowing of activities onto the immediately measurable.[31] Dr Andrew Cassels, former Director of Strategy, WHO, told us that, though it was less inclined than in the past to talk about HSS, DFID retains an admirable focus on system strengthening in its bilateral programmes.[32] **System strengthening is fundamental to the improvement of health outcomes. It is also the route to self-sufficiency for developing countries. We commend DFID for its strong focus on health system strengthening in its bilateral programmes. It is important that health outcome targets do not have the unintended consequence of reducing this focus.** ***We recommend DFID review its health targets to ensure that they are compatible with achieving its system strengthening objectives.***

25 HSS19 [DFID]

26 HSS19B [DFID]. The 36 per cent figure does not account for core funding of multilaterals, which is accounted for separately.

27 HSS22 [Action for Global Health]

28 HSS26 [Marie Stopes International]

29 HSS29 [Save the Children]

30 HSS2 [NICE International]

31 HSS19 [DFID]

32 Q2 [Dr Andrew Cassels]

International partners

Multilaterals

13. We heard concerns that multilaterals such as the Global Fund and GAVI, which receive a large amount of funding from DFID, show insufficient regard to HSS. This was partly because they were set up to tackle specific diseases, a task they had performed highly effectively, rather than to strengthen health systems.[33] However, Angela Spilsbury, DFID's senior health adviser in Ethiopia, told us that recent years have "seen a really large shift, with GAVI and the Global Fund moving towards a much more health systems approach".[34] The Global Fund's new funding model was praised in evidence, and Lynne Featherstone MP, Parliamentary Under-Secretary of State at DFID (the Minister), welcomed GAVI's HSS expenditure target.[35]

14. The multilaterals argued that disease-specific programmes are often effective vehicles for HSS. The Global Fund told us that while its interventions "may be born out of the need to respond to a particular disease […] they support the creation or development of key building blocks which serve the larger health system". Dr Michael Johnson, that organisation's Head of Technical Advice and Partnerships, described this as a "collateral effect".[36] The Global Fund aims, in partnership with other organisations, to "leverage" disease-specific programmes to have wider benefits at minimal additional cost.[37] For example, the Global Fund has financed the development of open-source health information software for Tanzania which, though designed for tracking AIDS, is now used across many diseases.[38] GAVI said that immunisation, by providing a point of contact between populations and health workers, gives an opportunity to deliver other services such as family planning.[39] Others cautioned against relying on "trickle-down effects", noting that vertical programmes could even act against the creation of sustainable health services, particularly where they compete with systems for scarce resources.[40]

15. We also heard concerns about the breadth of HSS-focused work by multilaterals. Dr Andrew Cassels argued that system interventions by the Global Fund and GAVI tend to be narrowly linked to their target health outcomes, providing inputs to a system without strengthening its operation.[41] Dr Julian Lob-Levyt, former CEO, GAVI, and former Chief Health Adviser, DFID, stressed that failing to acknowledge these narrow interests risked

33 Q69 [Dr Kalipso Chalkidou]

For example, programs supported by the Global Fund have 6.6 million people on antiretroviral therapy for AIDS, have tested and treated 11.9 million people for TB, and have distributed 410 million insecticide-treated nets to protect families against malaria. GAVI-supported programmes have immunised an additional 440 million in the world's poorest countries since 2000. See http://www.theglobalfund.org/en/about/results/ and http://www.gavialliance.org/advocacy-statistics/.

34 Q130 [Angela Spilsbury]

35 Q10 [Dr David Evans] and Q109 [Lynne Featherstone]

36 http://www.theglobalfund.org/en/about/diseases/hss/ and Q63 [Dr Michael Johnson]

37 Q63 [Dr Michael Johnson]

38 Q62 [Dr Michael Johnson]

39 HSS34 [International HIV/AIDS Alliance]

40 Q67 [Dr Kalipso Chalkidou] and HSS45 [Dr David Evans]

41 Q5 [Dr Andrew Cassels]

broad HSS being given insufficient attention.[42] The Independent Commission for Aid Impact (ICAI) noted that while GAVI had developed and maintained an effective vaccine distribution system in Kenya, this was not connected to wider health system reform.[43] Furthermore, Kara Hanson, Professor of Health System Economics, London School of Hygiene and Tropical Medicine, questioned whether these multilaterals have the requisite expertise to manage HSS programmes.[44] As they typically do not have permanent in-country representatives, they can also encounter problems in local coordination and identifying priority areas for improvement.[45]

Other donors

16. We were told that other major health sector donors have tended to "focus on quite narrow, short term results".[46] In our recent inquiry on recovery and development in Sierra Leone and Liberia, we received evidence that child mortality rates had fallen faster in Liberia, where USAID had taken a largely vertical approach, than in Sierra Leone, where DFID had concentrated on HSS.[47] However, Paul Wafer, Head of Sierra Leone and Liberia, DFID, expressed concern that USAID's approach was not sustainable or affordable in the long run.[48]

17. The Bill and Melinda Gates Foundation (Gates) is a major player in health development. It made total grants of $3.4 billion in 2012 and is now the largest contributor of voluntary funds to the WHO, outstripping all national governments.[49] Gates had a reputation of being focused on vertical interventions, and in the development of new technologies such as vaccines in particular, to the exclusion of HSS. This approach influenced the direction taken by other organisations, including the WHO.[50] We were told, by both Gates and DFID, that Gates now takes an increasingly system-centric approach.[51]

Gap-filling and coordination

18. Professor Kara Hanson told us that Gates sees its role as a "gap filler", specialising in areas where it has expertise, such as technology, and leaving other work to other organisations.[52] Similarly, we were told that GAVI's immunisation work "opens the space for others to come in on health systems".[53] The Minister acknowledged that DFID subscribes to this approach, explaining that it maps gaps in provision, stepping in or aside

42 Q41 [Julian Lob-Levyt]

43 HSS51 [ICAI]

44 Q6 [Prof Kara Hanson]

45 Q30 [Dr Andrew Cassels]

46 Q3 [Dr Andrew Cassels]

47 SLL7 [Save the Children]

48 Oral evidence taken on 1 July 2014, HC (2014-15) 247, Q70 [Paul Wafer]

49 HSS39 [Bill and Melinda Gates Foundation] and World Health Organization, Annex to the Financial Report, *Voluntary contributions by fund and by contributor for the year ended 31 December 2013* (WHA67.43).

50 Q4 [Prof Kara Hanson] and Q115 [Lynne Featherstone MP]

51 HSS39 [Bill and Melinda Gates Foundation] and Q115 [Lynne Featherstone MP]

52 Q4 [Prof Kara Hanson]

53 Q5 [Dr Andrew Cassels]

as necessary depending on which organisation has the comparative advantage.[54] However, it is not clear how this approach would work in countries where DFID does not have a bilateral programme.[55] DFID has reduced its portfolio of country programmes from 43 to 28 since 2010, meaning UK aid is increasingly delivered by multilaterals.[56]

19. **Despite some significant moves in the right direction, we are not convinced that DFID's main international partners give the development of health systems the same priority as DFID does. To some extent, this is understandable; multilaterals such as the Global Fund and GAVI were set up to tackle particular diseases, tasks they have performed with great distinction. But DFID now has fewer bilateral programmes and relies on multilaterals to manage an ever-greater proportion of its expenditure, often without in-country representatives.** ***We recommend that DFID conduct a detailed assessment, by country, of the extent to which existing funding arrangements enable its health systems strengthening objectives to be met.***

20. We also heard concerns about coordination between multiple donors in countries "pushing in different directions with different sets of priorities".[57] The International Rescue Committee used the example of South Kivu province in the Democratic Republic of Congo, where USAID, DFID, the Swiss Development Corporation and Cordaid were providing inefficient, duplicative assistance in overlapping geographical areas and local authorities were reluctant to reveal funding arrangements through fear of losing support.[58] As a result, the same activity was sometimes being financed several times.[59]

21. Poor coordination is a particular problem where there are separate funding flows for individual conditions, resulting in inefficient parallel systems such as "labs for TB built side-by-side with labs for AIDS".[60] Similarly, poor coordination between programmes could mean that the achievement of rapid results in one area is achieved at the expense of another; for example, health workers might be attracted from one programme to another through incentive payments.[61]

22. DFID has been a force for improved coordination, often through assisting governments in taking greater ownership of system strengthening efforts in their own countries.[62] For example, we heard particular praise for the Health Pooled Funds in South Sudan and Mozambique, Development Partners for Health in Kenya and the Health Transition Fund in Zimbabwe.[63]

---

54 Q111 [Lynne Featherstone MP]

55 Qq112-116 [Lynne Featherstone MP and Angela Spilsbury]

56 DFID, *Annual Report and Accounts 2013-14*, p55. Furthermore, DFID has announced plans to end bilateral aid to two of those 28 countries, India and South Africa, in 2015. See "*India: Greening announces new development relationship*", DFID press release, 9 November 2012 and "*UK to end direct financial support to South Africa*", DFID press release, 30 April 2013.

57 Q14 [Dr Andrew Cassels]

58 Cordaid is the Catholic Organisation for Relief and Development Aid.

59 HSS38 [International Rescue Committee]

60 Q10 [Dr David Evans]

61 HSS45 [Dr David Evans]

62 HSS27 [GRM Futures Group International]

63 HSS29 [Save the Children] and HSS20 [Crown Agents]

23. DFID stressed that its influence on coordination is dependent on the approach taken by governments and other donors. For example, in Kenya, where DFID does not fund the government because of corruption risks, ICAI found system strengthening efforts to be incoherent and unsustainable.[64] ICAI called on DFID, which unlike the Global Fund and GAVI has a permanent presence in the country, to take a more central coordinating role to establish a clear division of labour between development partners.[65]

24. DFID was instrumental in 2007 in the creation of the International Health Partnership (IHP+).[66] IHP+ does not disburse funds but is a framework for coordination, intended to put international principles for effective aid and development cooperation into practice in the health sector. The partners include developing countries, all of the major bilateral and multilateral donors in the health sector and civil society organisations. IHP+ aims to support single, country-led national health strategies, and we were told that it is "central to enhancing harmonisation and coordination of global health multilaterals".[67]

25. In December 2012, IHP+ identified seven systems-focused behaviours that international partners needed to adopt in order to be more effective, partly because donors were making less progress than developing country governments in putting IHP+ principles into practice.[68] We were told that DFID has made no clear response to these recommendations.[69] We also heard that, though the UK continues to fund IHP+ and serve on its steering committee, it is "no longer a prominent champion" of the IHP+ or the principles on which it was founded.[70]

26. **DFID expresses continued support for the International Health Partnership (IHP+), but it is not providing the impetus for increased coordination it did in the past. *We recommend DFID reaffirm its commitment to IHP+ by publishing on an annual basis the steps it is taking to implement, and encourage its international partners to adopt, IHP+ principles and recommended behaviours.***

64 HSS19 [DFID]

65 HSS51 [ICAI]

66 HSS19 [DFID]. See also International Development Committee, Fifth Report of Session 2007-08, *Maternal Health*, HC 66-I, para 17

67 International Health Partnership, 'Welcome to the International Health Partnership', accessed 1 September 2014 and HSS25 [Results UK]

68 International Health Partnership, 'Seven Behaviours', accessed 1 September 2014 and HSS29 [Save the Children]

69 HSS22 [Action for Global Health]

70 HSS29 [Save the Children]

3 Information and accountability

Expenditure and performance indicators

DFID

27. We heard conflicting evidence on whether DFID should dedicate a specific proportion of health expenditure to HSS. While this could provide clarity of focus, there was also a danger it could act to isolate HSS, whereas ideally it should be integrated with other programmes such as infectious disease control and reproductive health.[71]

28. DFID acknowledged that it can estimate only roughly how much it spends on HSS.[72] This means that HSS expenditure cannot be assessed for impact and value for money in the same way as that targeted on specific diseases.[73] Action for Global Health told us that DFID could be held more accountable for its health work if it published more detailed data on HSS expenditure, disaggregated by the area of the health system targeted.[74]

29. A lack of DFID performance indicators for HSS was also identified as a problem. Their absence is partly because system strengthening, particularly in areas such as corporate governance, is difficult to measure.[75] Yet, HSS indicators are potentially important as both a management tool, in helping to ensure that resources are allocated and used effectively, and a means of measurement, enabling DFID to be held accountable for its HSS work.[76] System measures could also be useful for assessing the efficacy of interventions in the short run as impacts on health outcomes may not register within the timeframe of projects.[77] For example, vaccination rates are more readily recorded than disease prevalence.

30. DFID uses system measures for monitoring some individual projects, but the Minister acknowledged that it was unsatisfactory that DFID does not have HSS indicators to assess its broader performance.[78] However, she expressed concern that targeting system measures could divert focus from health outcomes.[79] Professor Kara Hanson added that indicators can cease to be good measures once they become targets.[80] Results UK told us that DFID should publish proxies for system functionality, such as immunisation coverage and the proportion of children who are undernourished.[81] Others thought a narrowing of focus could be overcome by using broad indicators relating to universal health coverage,[82] stating

71 Q9 [Dr David Evans and Dr Andrew Cassels]

72 HSS19 [DFID]

73 HSS44 [Dr Julian Lob-Levyt]

74 HSS22 [Action for Global Health]

75 Q61 [Dr Kalipso Chalkidou]

76 HSS22 [Action for Global Health]

77 Q39 [Simon Wright]

78 Q118 [Jane Edmondson]

79 Q117 [Lynne Featherstone MP]

80 Q8 [Prof Kara Hanson]

81 HSS25 [Results UK]

82 Q8 [Prof Kara Hanson and Dr David Evans]

that measures of service coverage were effective measures of system performance,[83] and that effective HSS indicators already exist.[84] Jane Edmondson, Head of Human Development, DFID, told us that the Department was working with the WHO and World Bank to develop internationally-recognised system measures that could be used to monitor performance against post-2015 development goals.[85]

31. **It is impossible to know how well DFID is delivering its health systems strengthening strategy without knowing how much it spends or having indicators of its performance. Nor can DFID allocate its resources efficiently in the dark. These deficiencies are best addressed through the publication of data to internationally-agreed standards. This would ensure comparability and enable DFID to exert influence on its partners to improve their system strengthening work.** ***We recommend that DFID prioritise international agreement on measures of system strengthening expenditure and efficacy as part of discussions about the post-2015 development goals. We further recommend that, once agreed, these measures form part of DFID's regular reporting.***

International partners

32. The difficulties in assessing expenditure and performance in HSS are exacerbated by DFID channelling an increased proportion of its health expenditure through multilaterals.[86] Witnesses told us that these multilaterals are "less accountable for expenditure and results than providers of technical assistance contracted through a competitive process"[87] and that multilateralism takes DFID "one step away from accountability" for ensuring HSS is afforded appropriate attention.[88] DFID is unable to estimate what proportion of its core funding of multilaterals is spent on HSS.[89] This is a particular problem given our concerns, set out in the last chapter, that some major multilaterals do not share DFID's commitment to broad system strengthening.

33. The Minister told us that the Global Fund had been "a phenomenon" in driving down the price of important health commodities, such as antiretroviral drugs for HIV, and noted that the Multilateral Aid Review had found it and GAVI to be good value for money.[90] However, NICE International, though noting that a multilateral approach can bring economies of scale, said that there were "significant opportunities for efficiencies" in the expenditure of the Global Fund, which showed insufficient regard for the relative clinical effectiveness and value for money of different treatments.[91] The Malaria Consortium

83 Q34 [Dr David Evans]

84 Q33 [Dr Andrew Cassels]

85 Q118 [Jane Edmondson]

86 HSS19B [DFID]

87 HSS5 [Options Consultancy Ltd]

88 Q41 [Simon Wright]

89 HSS19B [DFID]

90 Q105 and Q120 [Lynne Featherstone MP]

91 Q60 and Q67 [Dr Kalipso Chalkidou] and HSS2 [NICE International]

recommended that DFID conducts further analysis to understand how its money is being spent by the Global Fund.[92]

34. Dr Julian Lob-Levyt told us that DFID could do better in assessing the HSS work of multilaterals by using more sophisticated indicators of their performance.[93] The Minister expressed concern that detailed value for money assessment of the work of multilaterals could be very resource-intensive.[94] Dr Kalipso Chalkidou, Director of NICE International, suggested that DFID would not have to do all such analysis itself and that the most effective means of holding multilaterals such as the Global Fund accountable for their expenditure would be for much more information to be published freely online.[95] Dr Michael Johnson said that the Global Fund would be happy to publish more data when possible, and the Minister said that DFID would seek to use its influence on the Global Fund's board to encourage them to be more transparent.[96]

35. **The Global Fund and GAVI have been highly successful in improving health outcomes in some of the poorest parts of the world. The multilateral model has advantages in economies of scale. However, it is unacceptably difficult to assess whether these organisations have genuinely and sufficiently switched focus to system strengthening. The multilaterals and their donors have a responsibility ensure that their assistance has the greatest possible impact. DFID has a responsibility to UK taxpayers to ensure that their money can be followed and is spent wisely.** ***We recommend that DFID insist that the Global Fund and GAVI publish better measures of system strengthening expenditure and performance. If DFID is not satisfied that system strengthening is being given sufficient priority by an organisation, and that organisation does not change, DFID should be prepared to withhold funds. We further recommend that DFID press the Global Fund and GAVI for programme data to be published online.*** **Freely accessible data will facilitate more accountability and scrutiny, and should also be of benefit to systems strengthening research.**

36. **Other donors do not share DFID's responsibilities to UK taxpayers. Private donors such as the Gates Foundation are rightly free to set their own priorities. However, health development is invariably a complex team effort. Transparency about expenditure and performance is imperative for these arrangements to work well.** ***We recommend that DFID work harder to encourage its partners to make more data on their health systems strengthening work freely available.*** **Accepting our recommendation that it publish more disaggregated statistics of the expenditure and performance of its own programmes would set a good example and make this task easier.**

92 HSS15 [Malaria Consortium]

93 Q38 [Dr Julian Lob-Levyt]

94 Q120 [Lynne Featherstone MP]

95 Q87 [Dr Kalipso Chalkidou]

96 Q94 [Dr Michael Johnson] and Q121 [Lynne Featherstone MP]

Research

37. DFID has long been a world leader in health systems research, and we heard praise for its evidence-based decision-making.[97] However, we were told that "knowledge on how best to strengthen health systems is limited" and that research in areas such as universal health coverage, system financing and non-communicable diseases was struggling to keep up with a growth in interest.[98] DFID aimed to "develop better ways of demonstrating the association between systems strengthening and health outcomes" as isolating such effects was more complex than for targeted interventions.[99] Nevertheless, health systems research accounts for less than one per cent of DFID expenditure on health, excluding core contributions to multilateral agencies, and is equivalent to only three per cent of the its total research and evidence division budget.[100] Over the five years to 2012-13, just 15 per cent of DFID's expenditure on health research was on systems.[101] Professor Kara Hanson told us that insufficient resources were being devoted to HSS research.[102]

38. The London School of Hygiene and Tropical Medicine described DFID's long-term approach to health systems research funding as a "key strength", though in oral evidence Professor Hanson, of the School, expressed concern that in recent years there has been "increased focus on quick results, and quickly getting research into policy and practice" which could limit the ambition of research.[103] Successful HSS research often took many years to come to fruition; for example, decades-old DFID-funded research on health contracting in South Africa had informed recent initiatives in post-conflict settings including Afghanistan.[104] We also heard concerns that the lessons of successful programmes in one country are not always spread effectively to others.[105]

39. **Understanding what works is an important part of effective and efficient intervention in health systems. At the moment, too little is known. DFID has a large research budget and allocating more of it to health systems is likely to be good value for money. *We recommend that DFID increase funding for health system strengthening research.***

97 HSS7 [London School of Hygiene and Tropical Medicine], HSS27 [GRM Futures Group] and HSS36 [Wellcome Trust]

98 Q12 [Prof Kara Hanson] and HSS7 [London School of Hygiene and Tropical Medicine]

99 HSS19 [DFID] and DFID, *Health position paper: delivering healthy results*, July 2013, p16

100 HSS19 and HSS19B [DFID] and DFID, *Annual Report and Accounts 2013-14*, p188

101 HSS19B [DFID]

102 Q12 [Prof Kara Hanson]

103 HSS7 [London School of Hygiene and Tropical Medicine] and Q2 [Prof Kara Hanson]

104 HSS7 [London School of Hygiene and Tropical Medicine]

105 HSS6 [Overseas Development Institute]

4 Foundations of strong health systems

40. The WHO has identified six key building blocks of an effective health system: services, workforce, information, commodities, finance and governance.[106] This structure has been criticised as neglecting preventative measures, inter-dependencies between the blocks, and the importance of system-wide processes.[107] The WHO acknowledges that "the building blocks alone do not constitute a system, any more than a pile of bricks constitutes a functioning building".[108] Although DFID endorses the building blocks, it claims to account for such concerns in its work already.[109] The evidence we received on particular elements of health systems focused on governance, finance, workforces, and community and public health.

Governance and finance

Governance

41. Our witnesses told us that effective health systems governance comprises efficient and accountable decision-making processes and the creation of incentives to support the achievement of objectives.[110] Dr Kalipso Chalkidou used the example of NICE International assisting the government of India with small changes to health insurance system governance such as improvements in administrative forms, contracts and records of conflicts of interest on decision-making committees. Though these were basic steps, they were "a necessary condition" for creating a more effective system.[111] Dr Dina Balabanova and Professor Martin McKee of the London School of Hygiene and Tropical Medicine told us that, while "there is no simple blueprint for a strong health system", studies of countries that had achieved significant health improvements identified "several critical factors underlying success, all intrinsically related to governance".[112]

42. DFID provided a case study of its governance work in Northern Nigeria, which was intended to address organisational bottlenecks that were hindering the effective functioning of the system. Its interventions included the establishment of State Primary Health Care Boards, providing technical support to the National Primary Health Care Development Agency and facilitating improvements to information systems.[113]

43. Other witnesses told us that DFID had tended to pay insufficient attention to strengthening leadership and governance.[114] NICE International wrote that "messier

106 World Health Organization, *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*, 2007, p3

107 HSS5 [Options Consultancy Ltd], HSS11 [The Open University] and HSS28 [Royal College of General Practitioners]

108 World Health Organization, *Systems thinking for health systems strengthening*, 2009, p31

109 HSS19 [DFID]

110 Q24 [Dr Andrew Cassels] and Q29 [Dr David Evans]

111 Q92 [Dr Kalipso Chalkidou]

112 HSS16 [Dr Dina Balabanova and Prof Martin McKee]

113 HSS19 [DFID]

114 HSS1 [Malaria Consortium] and HSS20 [Crown Agents]

governance strengthening and institutional capacity-building initiatives", which were often dependent on "local politics and context", tended to be neglected.[115] Dr Kalipso Chalkidou added that DFID's governance work suffered from being "diluted down" through a lack of interest on the part of outcome-focused multilaterals.[116]

44. Improving the governance of decentralised health systems could be particularly problematic.[117] In its recent report on child mortality, ICAI highlighted the risks posed to DFID's HSS work in Kenya by the ongoing process of devolution in that country, which saw 65 per cent of the 2013-14 health budget managed locally. ICAI said that the risk of local authorities failing to spend this money on health was high, and noted the political incentive to prioritise highly visible items, such as hospitals, ambulances and bed net distributions, for funding. ICAI warned that devolution was even more challenging for GAVI and the Global Fund, which rely on government systems and do not have the capacity or presence to engage with local authorities.[118]

45. It can be difficult to quantify the effects of governance programmes and therefore to demonstrate tangible results. We were told that this has contributed to the perceived inadequate expenditure on governance.[119] Dr Andrew Cassels countered that, though DFID tended to communicate the successes its of programmes through health outcomes, debate on the NHS is dominated by discussion of systems indictors such as waiting times or geographical disparities in provision.[120]

Finance

46. An effective health financing system raises adequate funds for health, ensuring that people can use services and are not impoverished by paying for them. It also provides incentives for the system to operate more efficiently.[121]

47. Finance and governance are closely related issues: sufficient revenue must be raised to support a health system, and health ministries must make the political case for money to be spent on health and HSS rather than other priorities.[122] DFID described health systems finance as "essentially a very political issue".[123] Dr Fiona Samuels of the Overseas Development Institute (ODI) and Dr Dina Balabanova of the London School of Hygeine and Tropical Medicine told us that:

> While there is increasing recognition that political forces drive investment in health and health systems to a large extent, health system reform and health system

115 HSS2 [NICE International]

116 Q60 [Dr Kalipso Chalkidou]

117 HSS5 [Options Consultancy Ltd]

118 ICAI, *DFID's Contribution to the Reduction of Child Mortality in Kenya*, March 2014, paras 2.48-2.50

119 Q61 [Dr Kalipso Chalkidou]

120 Q28 [Dr Andrew Cassels]

121 HSS19 [DFID]

122 Q14 [Prof Kara Hanson]

123 HSS19 [DFID]

strengthening efforts often do not incorporate recognition of the complexity of the policy process and its inherently political nature.[124]

48. We heard concerns that generous disease-specific development financing has promoted a culture of reliance on donors.[125] This hypothesis is supported by poor progress by most African governments on the target, set out in the 2001 Abuja Declaration, to spend at least 15 per cent of annual government budgets on health. Of 50 African Union countries for which WHO data are available, just six met the target in 2012.[126]

49. Domestic investment in the health sector can yield positive results. Rwanda, the country in Africa with the highest proportion of government expenditure allocated to health, has seen significant improvements in health outcomes and has been making progress towards self-sustainability by focusing on strengthening its health system and investing in health professionals.[127] Dr David Evans, Director of Health Systems Governance and Financing, WHO, told us that developing country governments should be expected to do more to raise revenue and allocate it to health.[128] The Minister told us that there were challenges in convincing governments that it was their responsibility to ensure public services were provided and that investment in health was good value for money.[129]

50. We asked the Minister whether DFID used local parliamentarians as advocates for health system expenditure and reform. She expressed reservations that parliamentarians in many developing countries did not have as strong a link to their constituencies as in the UK system. While DFID had parliamentary strengthening programmes focused on finance and audit, she was unaware of any health-specific interventions.[130]

51. The Malaria Consortium argued that "long-term sustainable change will never be achieved without increased support for countries to develop their own sources of health financing".[131] Health Poverty Action agreed that enabling countries to collect taxes and tackle tax evasion should be an urgent priority, though Crown Agents stressed that such work needed to be properly integrated with HSS programmes.[132] Improved revenue collection was necessary, but not sufficient, for greater domestic spending on health.[133]

52. Funding allocated to health is often poorly spent.[134] We were told that there is extensive evidence that resources are not efficiently allocated and that far more could be achieved with the same funding by employing more effective priority-setting mechanisms. NICE International referred to "ad hoc decision-making on budgets, driven more by inertia and

124 HSS6 [Dr Fiona Samuels and Dr Dina Balabanova]

125 HSS44 [Dr Julian Lob-Levyt]

126 World Health Organization

127 World Health Organization, Global Health Expenditure Database and Rwanda country profile on the Africa regional office website

128 Q16 [Dr David Evans]

129 Q131 [Lynne Featherstone MP]

130 Q133 [Lynne Featherstone MP]

131 HSS15 [Malaria Consortium]

132 HSS42 [Health Poverty Action] and HSS20 [Crown Agents]

133 Q17 [Prof Kara Hanson and Dr David Evans]

134 HSS45 [Dr David Evans] - the WHO estimates that between 20 and 40 per cent of health resources are wasted.

interest groups than science, ethics, and the public interest".[135] We heard of funding for "high-cost, low-impact interventions when low-cost, high-impact options are underfunded" and public subsidies for treatments considered not to be cost-effective in the world's wealthiest countries.[136] For example, Avastin, a breast cancer treatment deemed not to be value for money in the UK, is routinely offered in Colombia, whereas screening for cervical cancer is not.[137] Oxfam was critical of the Affordable Medicines Facility Initiative, which involves the sale of malaria treatment in grocery shops, funded by DFID and partners through the Global Fund. They argued this was counter-productive as it led to sales of medicine without proper diagnosis or contact with health professionals and suggested it indicated that value for money principles were not being applied across all DFID spending.[138]

53. DFID has taken some innovative approaches to health system finance. With DFID support, the World Bank has been trialling results-based financing in Argentina, Burundi and Rwanda whereby project financing and disbursements are explicitly linked to pre-agreed results. The World Bank argued this has increased accountability, reduced inefficiency and achieved impressive outcomes.[139] Others praised DFID for its inventive voucher programmes for reproductive health in Malawi, Pakistan and Rwanda; and for subsidising private health insurance schemes for the poor in Ghana, Kenya and Nigeria.[140] We were told that DFID's approach to interventions in health systems financing is pragmatic, not always arguing in favour of tax-funded systems like the NHS but adapting to local circumstances.[141] However, it may underestimate the international appetite for UK systems governance and finance advice based on the NHS experience.[142] We consider this further in chapter 5.

54. **The lack of progress by many African governments on the health expenditure commitment in the 2001 Abuja declaration is very worrying. It suggests a culture of reliance on aid that is irreconcilable with ultimate self-reliance. DFID aid should never be a blank cheque.** ***We recommend that, as well as making the positive case for expenditure on health systems, DFID work with developing country governments to agree medium-term aid plans based on concordance with the Abuja target and fund accordingly, taking a tough line with governments which are unwilling to take responsibility for the long-term health of their own populations. We also recommend that DFID make better use of local parliamentarians and medical professionals as advocates for prioritising expenditure on health systems over other demands.***

55. **Health systems governance and finance are complex political issues. The outcomes of intervention in these areas tend to be uncertain and expenditure on them can be harder to sell to electorates, donors and developing country governments. DFID's**

135 HSS2 [NICE International]

136 HSS45 [Dr David Evans]

137 HSS2 [NICE International]

138 HSS23 [Oxfam]

139 HSS33 [World Bank Group]

140 HSS26 [Marie Stopes International]

141 Q18 [Prof Kara Hanson]

142 Q38 [Simon Wright]

international partners, given their narrower objectives, are also less likely to be involved. However, health systems governance and finance are vital to properly functioning and ultimately self-sustaining health systems. DFID must lead the way on strengthening them, including making the case for such interventions to sceptics at home and abroad.

Workforces and community health

Health workforces

56. We were told that "trained, supported, motivated and employed" staff were necessary for any successful health intervention.[143] For example, skilled care before, during and after childbirth can be the difference between life and death, yet only 46 per cent of women in low-income countries benefit from it.[144] Witnesses argued that the fundamental problem was a "numbers game" and the global shortage of health workers was a barrier to achieving national and international health aims.[145] This chimed with our experience on our recent visit to Sierra Leone, where we heard that a shortage of doctors, nurses and midwives was a major obstacle to health system improvement.[146] We heard that a scarcity of specialist expertise was a major obstacle to tackling conditions such as neglected tropical diseases. The Global Health Workforce Alliance (GWHA) estimates that more than seven million additional health workers are required to deliver basic services to all, a deficit that could rise to 13 million by 2035 because of projected population growth.[147]

57. Wealthy countries, including the UK, have a history of undermining the health systems of some of the poorest countries through the recruitment of their doctors and nurses.[148] An NHS Code of Practice, which states that "international recruitment of healthcare professionals should not prejudice the healthcare systems of developing countries",[149] was introduced in 2001 and a Global Code of Practice was adopted by the World Health Assembly in 2010.[150]

58. Health worker migration to the UK from outside the EU has declined in recent years, though this trend may in part be due to a cyclical, and reversible, fall in demand.[151] We heard concerns that there is insufficient collaboration between DFID and the Department of Health on workforce planning and that the ban on active recruitment from developing countries does not cover the private sector, including care homes.[152] Health Poverty Action argued that source countries should receive some form of restitution should their health

143 HSS25 [Results UK]

144 World Health Organization, *Maternal Mortality Factsheet*, May 2014

145 Q76 [Dr John Howard], HSS37 [Sightsavers] and HSS40 [UK Coalition against Neglected Tropical Diseases]

146 International Development Committee, Sixth Report of Session 2014-15, *Recovery and Development in Sierra Leone and Liberia*, forthcoming

147 Global Health Workforce Alliance, *A Universal Truth: no health without workforce*, 2013, p36

148 HSS42 [Health Poverty Action]

149 NHS Employers, *Code of Practice for international recruitment*

150 World Health Organization

151 HSS22 [Action for Global Health]

152 HSS17 [VSO] and HSS22 [Action for Global Health]

workers be recruited by UK employers, though they acknowledged that further work would be required to ascertain how this might happen in practice.[153]

59. The Minister highlighted the Medical Training Initiative, under which a small number of overseas doctors undertake two years' training in the UK before returning to their home country, as an example of good practice.[154] However, we were told that the Government could do more to promote such schemes and that there could be problems obtaining visas for visiting trainee doctors.[155] Lord Crisp drew attention to the success of specialist in-country medical training in Zambia, arguing that there was high demand for such schemes and DFID could do much more to support them.[156] Dr John Howard of the Academy of Medical Royal Colleges told us that while there was a lot of potential in in-country training, many existing local programmes were very weak.[157] As it was, a shortage of affordable medical training was creating a bottleneck in some countries, meaning there were too few adequately trained medical professionals to keep up with increases in public access to health services.[158]

60. ***The staffing of the UK health sector should not be at the expense of health systems in developing countries. We recommend DFID work with the Department of Health to review its approach to the UK recruitment of health workers from overseas. This review should consider options for compensating source country systems, promoting training schemes that involve a temporary stay in the UK, and strengthening local programmes to enable more medical training to take place in-country.***

61. DFID is currently reviewing its approach to human resources for health (HRH).[159] Currently, it does not monitor how much it spends on HRH and does not have any HRH targets or performance measures, precluding effective evaluation. We were told that insufficient evidence of the best ways to strengthen health workforces hampers DFID's work and limits its leverage in encouraging its international partners to prioritise HRH.[160] Witnesses called for DFID to have a more ambitious and comprehensive HRH strategy and to be more vocal in pushing for a global HRH strategy under the auspices of the GHWA.[161]

62. **Doctors, nurses and other health professionals are at the centre of any well-functioning health system. We are concerned that DFID does not know how much it spends on human resources for health and or have means of monitoring its performance.** ***We recommend that DFID's review of its approach to human resources for health extends to an ambitious strategy which would set an example of best practice to international partners.***

153 HSS42 [Health Poverty Action]

154 Q138 [Lynne Featherstone MP]

155 HSS17 [VSO] and HSS18 [Royal College of Physicians of Edinburgh]

156 Q50 [Lord Crisp]

157 Q76 [Dr John Howard]

158 HSS8 [Royal College of Physicians]

159 HSS22 [Action for Global Health]

160 HSS22 [Action for Global Health]

161 HSS25 [Results UK], HSS37 [Sightsavers] and HSS29 [Save the Children]

Community health workers

63. DFID noted that its training of health staff had "focussed particularly on community health workers and skilled birth attendants", resulting in an additional 2.75 million births having a skilled attendant over the past three years.[162] Community health workers (CHWs), with limited training, can play an important role in delivering primary care, from prevention and health promotion to diagnosis and basic treatment.[163]

Box 2: The Health Extension Programme in Ethiopia

In Ethiopia, DFID support to the health budget has enabled over 30,000 Community Health Workers (CHWs), known as Health Extension Workers (HEWs), to be trained. Health services are now available to rural communities that did not previously have access. Primary care coverage has increased to 93 per cent, close to universal coverage, from 77 per cent in 2005 and 30 per cent in 1991.[164] Provision of preventative health care and basic treatment for conditions such as malaria, diarrhoea and pneumonia by HEWs has been credited for rapid improvements in health outcomes, including Ethiopia's achievement of its child mortality Millennium Development Goal.[165] Many other countries are now looking to use the Ethiopian model in developing their own CHW programmes.[166]

64. Results UK told us that CHWs "can effectively deliver high quality health interventions to improve health outcomes to at least the level of other trained professionals". They can act as an important link between formal health structures and primary care provision in the community, assist in tracking patients and encourage communities to participate in preventative activities.[167] Witnesses suggested that CHW programmes should be scaled-up and that DFID should both champion CHWs and support their integration into national health strategies.[168]

65. The REACHOUT Consortium noted that "close-to-community" programmes "are increasingly being initiated and scaled up in response to the human resources for health crisis", but expressed concern at the lack of evidence on how best to support such programmes.[169] Dr Julian Lob-Levyt warned that CHWs "have been seen as magic bullets for under-funded and poor-performing health services", but that they required sophisticated integration with other services.[170] Oxfam stressed the importance of complementing CHWs with a system of referral to more expert care, a point reiterated by

162 HSS19 [DFID]

163 The WHO's preferred definition of a CHW is: "Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers".

164 Q135 [Angela Spilsbury] and HSS25 [Results UK]

165 Q135 [Angela Spilsbury]

166 HSS25 [Results UK]

167 HSS17 [VSO] and HSS24 [Oxfam Zambia]

168 For example, HSS25 [Results UK], HSS17 [VSO] and HSS40 [UK Coalition against Neglected Tropical Diseases]. Michael King and Elspeth King (HSS41) similarly advocated DFID concentrating on "training large numbers of lower grade health staff".

169 HSS13 [REACHOUT Consortium]

170 Q51 [Dr Julian Lob-Levyt]

Angela Spilsbury of DFID.[171] Simon Wright of Action for Global Health said that CHW schemes had not resulted in falling neonatal mortality as CHWs were not able to deal with complications and expressed concern that such programmes were further examples of "quick wins" being chased.[172] Lord Crisp told us that many countries had more urgent demand for the training of high-level specialists.[173]

66. **Community health workers can be an important part of a developing health system. They provide flexibility and enable programmes to be scaled-up very quickly. However, they should not be seen as an easy remedy for all health system problems, nor as a substitute for properly trained and specialist health professionals. As in other areas, DFID would benefit from sounder monitoring and a better evidence base in assessing the role to be played by community health workers in individual countries.**

Community care and public health

67. We received a large volume of evidence supporting a greater focus on community and decentralised health service provision, beyond that which can be offered by CHWs. Dr Dina Balabanova and Professor Martin McKee noted that system strengthening tended to focus on formal and government structures, which accounted for a small proportion of healthcare in many countries.[174] The International HIV/AIDS Alliance noted that "grassroots community organisations deliver a substantial share of health services" in many countries and that they could be important in reaching the most marginalised population groups.[175]

68. Action for Global Health stressed the importance of community engagement in improving preventative public health services and addressing the wider determinants of good health such as WASH (water, sanitation and hygiene).[176] The WHO defines public health as "all organised measures to prevent disease, promote health, and prolong life among the population as a whole", adding that "its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases".[177] DFID claimed to take a "public health approach" to HSS, arguing that the provision of preventative services was an important factor in improving both health outcomes and system efficiency.[178] However, Dr John Howard feared that "public health has almost been forgotten" and was insufficiently integrated with other programmes.[179] In 2012, DFID found that there was potential for efficiency gains by better aligning its WASH and health programmes.[180]

171 HSS23 [Oxfam] and Q135 [Angela Spilsbury]

172 Q51 [Simon Wright]

173 Q50 [Lord Crisp]

174 HSS16 [Dr Dina Balabanova and Professor Martin McKee]

175 HSS34 [International HIV/AIDS Alliance]

176 HSS22 [Action for Global Health]

177 World Health Organization, Online glossary, accessed 1 September 2014

178 DFID, *Health position paper: delivering health results*, July 2013, p2 and HSS19 [DFID]

179 Q74 [Dr John Howard]

180 DFID, *WASH Portfolio Review*, 2012, para 28

Box 3: Trachoma elimination

The UK Coalition against Neglected Tropical Diseases told us that a coordinated health systems approach was vital to a SAFE (Surgery, Antibiotics, Facial cleanliness, Environment) strategy to eliminate blinding trachoma by 2020:

"Surgical interventions, antibiotic distribution and health promotion activities need to be delivered through a health system in order to reach trachoma endemic communities. However, many trachoma-endemic countries have a weak health system with even weaker primary healthcare, as well as little capacity to work across ministries and sectors to deliver components such as water, sanitation and hygiene. The current momentum in reinvigorating primary healthcare with integration of eye care and health system strengthening, provides a real opportunity in the drive towards trachoma elimination."

Currently, only 13 per cent of people receive the treatment they require for this disease.[181]

69. One possible explanation for the poor integration of preventative care in HSS work is that the standard models of HSS, such as the WHO's six building blocks, do not explicitly include public health. This could lead to separate preventative and curative programmes and institutions.[182] We were also told that HSS tends to be associated with ensuring access to services rather than public health campaigns.[183] In our recent Report, *Disability and Development*, we expressed reservations that DFID underestimates the importance of preventative care in its health budget.[184] The balance of evidence to this inquiry added to those concerns.

70. Other witnesses said it was important not to over-rely on decentralised provision. Dr Julian Lob-Levyt emphasised the importance of integrated, national services and cautioned against establishing clinics to be run by external organisations in isolation from the wider health system.[185] We were also warned that there was a risk of undermining national health systems through decentralisation, which could "reduce people's expectation that their Government is going to be accountable for the delivery of their healthcare".[186]

71. Writing about the ongoing Ebola epidemic in Sierra Leone, Matthew Clark of the Welbodi Partnership said that the health system was undermined by a lack of trust, stemming from an absence of both transparency about how donor funds are spent and a means of holding to account those in charge.[187] The Tony Blair Faith Foundation told us that community and faith organisations were often trusted by local populations and could be used to encourage greater use of health services.[188] Under-provision is sometimes attributable to low demand for healthcare, or the difficulties in reaching facilities, as well as

181 HSS40 [UK Coalition against Neglected Tropical Diseases]

182 HSS16 [Dr Dina Balabanova and Professor Martin McKee]

183 Ibid

184 International Development Committee, *Disability and Development*, Eleventh Report of Session 2013–14, HC 947, para 79

185 Q48 [Dr Julian Lob-Levyt]

186 Q48 [Simon Wright]

187 Matthew Clark, *Ebola epidemic heightened by poor facilities and distrust of healthcare*, Guardian Poverty Matters Blog, 13 August 2014

188 HSS12 [Tony Blair Faith Foundation]

under-supply.[189] In Zambia, church provision of health services is supported by the government, well-integrated with the rest of the system and is more effective as a result.[190]

72. We received in evidence several examples of cultural and informational barriers to system strengthening. A scorecard scheme in Afghanistan, designed to understand the needs and concerns of local people, revealed that patients thought they were only receiving familiar basic painkillers because the drugs they were given were similar small white tablets.[191] We were told the story of a health centre in Uganda that was closed because the manager had taken his sick mother to visit the witchdoctor. [192] We also heard that, in Sierra Leone, community volunteer drug distributors had been successful in both improving awareness of neglected tropical diseases and combating discrimination against suffers of such illnesses.[193]

73. Some barriers to health service access affect particular social groups. We were told that indigenous Guatemalan women had maternal mortality rates three-times the national average, partly reflecting exclusion from decision-making processes, language barriers and discrimination.[194] The International HIV/AIDS Alliance said that there had been a global increase in discrimination against lesbian, gay, bisexual, and transgender people, including recent laws against homosexuality in India and Nigeria, which manifested in unequal access to services. They argued that this threatened progress in HSS and called on DFID's health programmes to be accompanied by a broader strategy of strengthening communities and defending human rights.[195] In our 2012 Report on *Violence against Woman and Girls*, we noted both that abuse acted as an obstacle to use of health services and that the health sector could be better used to help tackle violence and its consequences.[196] In its 2013 *Health Position Paper*, DFID similarly identified factors such as the low and unequal status of women and girls, and early or forced marriage as limiting access to healthcare.[197]

74. **Community services and public health are important parts of an effective and efficient health system. There can be a tendency, driven partly by standard health system models, to focus on curative care in formal national systems. We heard concerns that DFID sometimes falls into this trap. It is too hard to assess whether this is the case. *We recommend that, in publishing the disaggregated data recommended earlier in this Report, DFID prioritise community services and public health.***

75. **DFID rightly identifies factors ranging from superstition and mistrust of formal health systems to discrimination and violence against women and girls as obstacles to**

189 HSS4 [Riders for Health]. See also HSS10 [Future Health Systems] for an example of an effective maternal health intervention in Uganda involving a voucher system for use of local motorcycle taxis.

190 Q48 [Dr Julian Lob-Levyt]

191 HSS10 [Future Health Systems]

192 HSS43 [Dr Sarah Colenbrander]

193 HSS6 [Dr Fiona Samuels and Dr Dina Balabanova]

194 HSS42 [Health Poverty Action]

195 HSS34 [International HIV/AIDS Alliance]

196 International Development Committee, *Violence Against Women and Girls*, Second Report of Session 2013–14, HC 107, paras 19 and 69

197 DFID, *Health position paper: delivering health results*, July 2013, p12

improving healthcare. ***We recommend that DFID press its international partners, including national governments, to tackle unacceptable cultural barriers to access to health services.***

5 Making better use of NHS expertise

76. The NHS was judged by the Commonwealth Fund in June 2014 to be the best of eleven major wealthy health systems and has an excellent international reputation.[198] DFID makes use of NHS expertise through programmes such as the Health Partnership Scheme and its funding of NICE International. In this chapter we consider whether DFID might work more closely with the NHS.

Health Partnership Scheme and volunteering overseas

77. The Health Partnership Scheme (HPS), operated by the Tropical Health and Education Trust (THET), facilitates over 80 institutional health partnerships between UK-based health organisations and their counterparts in low and middle-income countries.[199] This enables skills transfer, the exchange of ideas and the building of support for broader UK development priorities.[200] To date, over 20,000 health workers have received training, education and peer-to-peer support. The HPS has two main components: a grants mechanism for projects proposed by partnerships, and activities to support and develop partnerships so that they are better equipped to deliver effective projects.[201] Grant recipients include NICE International and several of the Royal Colleges.[202] DFID has extended support for the scheme, which originally covered 2010-2015, to 2017, committing an additional £10 million in funding.[203]

78. In 2013, the All-Party Parliamentary Group on Global Health praised the HPS as "the most effective government action to support NHS overseas work in recent years", noting its "transformative effect".[204] More than 1,000 volunteers from the NHS have been supported by the scheme.[205]

79. The Academy of Medical Royal Colleges has been highly supportive of the HPS and other initiatives to promote greater volunteering overseas by NHS professionals, arguing that they are of mutual benefit. In particular, individuals who volunteer often acquire personal and professional skills that are transferable to the NHS;[206] international health partnerships can help stimulate innovation in both settings; and the UK benefits from

198 Q78 [Dr Kalipso Chalkidou] and the Commonwealth Fund, *Mirror, Mirror on the Wall, 2014 Update*, June 2014. The Commonwealth Fund study evaluated the health systems of Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the United States.

199 THET is a "THET is a specialist global health organisation that educates, trains and supports health workers through partnerships, strengthening health systems and enabling people in low and middle income countries to access essential healthcare". See http://www.thet.org/.

200 THET, *Support for Health Partnership Scheme extended beyond 2015*, 23 May 2014

201 HSS47 [THET]

202 THET, Homepage, accessed 1 September 2014

203 HSS6 [Dr Fiona Samuels and Dr Dina Balabanova]

204 All-Party Parliamentary Group on Global Health, *Improving Health at Home and Abroad: How overseas volunteering from the NHS benefits the UK and the world*, 2013, p34

205 HSS47 [THET]

206 Q53 [Lord Crisp]

goodwill and extended influence.[207] This view was echoed by Lord Crisp, former Chief Executive of the NHS, who described volunteering overseas as "a great potential win-win".[208]

80. We heard that DFID had recently become more interested in assisting with volunteering programmes.[209] However, volunteering schemes are said to be small-scale, fragmented, unsystematic and arguably underfunded.[210] These concerns were familiar to us: in our recent Report on *Democracy and Development in Burma* we recommended the creation of a small fund to support an impressive proposal by University College London Medical School, the Royal College of Physicians and others to establish a partnership programme with colleagues in Rangoon.[211]

81. Volunteering can meet internal resistance in the NHS, from employees who fear for their careers or hospitals who fear losing staff.[212] There is also a lack of formal recognition of the value of volunteering for professional development.[213] Lord Crisp called for greater inventiveness in making volunteering more viable for health professionals, drawing attention to a proposal before USAID for volunteer doctors to be excused a proportion of their student loan as an incentive.[214] He argued that a relatively small financial outlay would enable the development of a more systematic programme, suggesting that it could form part of training for some student doctors.[215] The Minister told us that the NHS, in conjunction with DFID, the Department of Health and others, would publish a new framework for volunteering in the NHS in the coming months.[216]

82. **Volunteering overseas by UK medical staff can be highly advantageous for developing health systems. Through the personal and professional development of individuals, the sharing of best practice and the building of global contacts, it can also be of great benefit to the NHS. Existing volunteering schemes, though often successful, are small-scale and fragmented. The Health Partnership Scheme is highly effective, but its funding is a drop in the ocean. Volunteering schemes need coordination, structure and scaling up.**

83. **NHS staff should be supported in seeking to apply their skills where need is greatest. *We recommend that the new NHS framework for volunteering establishes a formal structure to facilitate the participation of many more medical professionals, including***

207 Academy of Medical Royal Colleges, *Statement on Volunteering: Health Professional Volunteers and Global Health Development*, 25 March 2013

208 Q53 [Lord Crisp]

209 Q58 [Dr John Howard]

210 QQ52-3 [Lord Crisp], Q58, Q80 and Q85 [Dr John Howard] and Academy of Medical Royal Colleges, *Statement on Volunteering: Health Professional Volunteers and Global Health Development*, 25 March 2013Q80 [Dr John Howard]

211 International Development Committee, Ninth Report of Session 2013-14, *Democracy and Development in Burma*, HC 821, para 148

212 Q78 [Kalipso Chalkidou], Q83 [Dr John Howard]

213 Academy of Medical Royal Colleges, *Statement on Volunteering: Health Professional Volunteers and Global Health Development*, 25 March 2013

214 Q53 [Lord Crisp]

215 Q52 [Lord Crisp]

216 Q140 [Lynne Featherstone MP]

through extended sabbaticals, and makes clear that volunteering overseas is valued and consistent with career progression. DFID should provide the necessary funds to support these more ambitious schemes. We further recommend that DFID investigates means of supporting those who volunteer, including continuing NHS pension contributions and paying down student loans.

Management and finance skills

84. We were told that economic development and increasing complexity in health systems mean that greater expertise in managing and financing health services than can be offered by established international aid organisations is now required.[217] Management skills were identified as a key gap in developing systems, including by the Minister.[218] We also heard that the problems faced by developing systems were often the same as those in rich countries.[219] The NHS is home to a wealth of health systems management and finance expertise, and that knowledge is held in high international regard.[220]

85. One example of NHS management and finance expertise being used in development is NICE International. The National Institute for Health and Care Excellence (NICE) is the part of the NHS responsible for advising on cost-effectiveness and the allocation of resources. Its small international arm, which was founded in 2008, has offered advice to more than 60 overseas governments on making informed prioritisation decisions. It does not use NHS resources and is funded jointly by DFID, the Gates and Rockefeller Foundations and the World Bank.[221] DFID repeatedly referred to NICE International's work as examples of effective HSS in evidence to us.[222] We asked NICE International's Dr Kalipso Chalkidou what would help the organisation extend its work. Rather than additional money, she called for improved coordination between DFID and other government departments and for the Government to be more confident in promoting NHS governance principles overseas.[223]

86. **Demand for NHS staff does not end with doctors and nurses. Though often criticised at home, the NHS is held in high international regard and many countries would greatly benefit from the assistance of those expert in managing and financing such a successful health system. In turn, NHS managers would benefit from tackling familiar problems in unfamiliar settings. This is a challenge to traditional development models and DFID must be sufficiently agile to adapt to changing and increasingly complex needs. NICE International is a successful example of how NHS expertise can benefit overseas systems, and leverage funds from other donors in the process.** ***We recommend that DFID establish a clear strategy for how UK government should work in partnership with the NHS to support overseas health systems.***

217 HSS44 [Dr Julian Lob-Levyt]

218 Q31 [Prof Kara Hanson] and Q138 [Lynne Featherstone MP]

219 Q39 [Dr Julian Lob-Levyt]

220 Q53 [Dr Julian Lob-Levyt, Simon Wright and Lord Crisp] and Q90 [Dr Kalipso Chalkidou]

221 HSS2 [NICE International]

222 HSS19 [DFID] and Qq115, 133 and 138 [Lynne Featherstone MP]

223 Q90 [Dr Kalipso Chalkidou]

6 DFID leadership

Leadership in systems strengthening

87. DFID reasserted its commitment to HSS in its July 2013 *Health Position Paper*.[224] The sentiments expressed in that document have been widely praised.[225] However, we also heard criticisms that it does not set out a clear strategy on HSS, indicate in detail how DFID intends to strengthen systems, or provide any clear targets or indicators.[226]

88. While DFID has retained an HSS focus in its bilateral programmes, it has done so quietly, preferring to publicise narrow outcome indicators,[227] and thus failing to capitalise on its international stature to promote HSS. NGOs have called on DFID to be a louder advocate of HSS, such as through promoting the International Health Partnership principles it was instrumental in establishing, and to invest more ministerial time in HSS promotion, whereas it declined to send a minister to the Third Global Forum on Human Resources for Health.[228] Dr Andrew Cassels told the Committee that DFID has "slightly lost […] thought leadership" on system strengthening, while STOPAIDS went as far as to say DFID have "ceded their role as leaders" in the field.[229]

89. As well as directly supporting HSS initiatives, we heard that DFID encourages other donors to do likewise.[230] The Gates Foundation, Global Fund and GAVI attribute an increased HSS focus in their work to the influence of DFID.[231] One of DFID's key opportunities to exert greater influence comes from its position on the boards of major multilaterals. We were told that DFID "has great know-how and also great funding power" to change the outlook of multilaterals.[232] For example, the UK played a significant role in establishing the UNITAID Medicine Patent Pool, a mechanism to promote access to generic HIV medicines which had resulted in sustained price decreases.[233] The Minister told us that DFID had ensured that GAVI had established more stable supply chains and vaccine markets in developing systems that would be sustainable after its support ended.[234]

90. DFID's influence is, however, limited: it is, for instance, just one of 20 members of the Global Fund's board.[235] Pressure from other donors with contrasting priorities could be a "pretty strong" influence on the approach of multilateral organisations.[236] For example, we

224 DFID, *Health position paper: delivering health results*, July 2013, p2

225 e.g. HSS29 [Save the Children] and HSS17 [VSO]

226 HSS29 [Save the Children] and HSS22 [Action for Global Health]

227 Q2 [Dr Andrew Cassels]

228 Q38 [Simon Wright], HSS22 [Action for Global Health] and HSS 29 [Save the Children]

229 Q7 [Dr Andrew Cassels] and HSS30 [STOPAIDS]

230 Q58 [Dr Kalipso Chalkidou]

231 HSS39 [Gates Foundation], HSS49 [Global Fund] and HSS31 [GAVI Alliance]

232 Q70 [Dr Kalipso Chalkidou]

233 HSS23 [Oxfam]

234 Q124 [Lynne Featherstone MP]

235 Q66 [Dr Michael Johnson]

236 Q4 [Dr David Evans]

were told that the WHO's attention had been diverted from its areas of HSS expertise towards programme delivery.[237] In the face of this, we heard calls for DFID to take a more assertive stance, particularly at strategic level. This was particularly important in middle-income countries where DFID does not have a bilateral programme,[238] or where a central, coordinating role was required.[239] We asked the Minister how DFID exercises its influence on its international partners to promote HSS. While we accept that such negotiations are inevitably a combination of "fight" and "constant dialogue", we were concerned by her inability to provide more convincing practical examples.[240]

91. **DFID's own health systems strengthening work is world-leading. But that is not enough; DFID must be an active and vocal systems champion, driving the international agenda by experience and example, pressing other donors to prioritise systems strengthening and exercising its influence on the boards of multilaterals to ensure that they have genuine systems focus at strategic level. As it is, DFID, and its ministers in particular, are insufficiently vocal. This is a particular concern in the increasing number of countries where DFID does not have a bilateral programme.** ***We recommend that DFID publish a clear health strategy, including measures of performance, setting out the rationale for system strengthening, how it intends to strengthen systems in its own work and what it expects from its international partners.***

Post-2015 development goals and universal health coverage

92. The Millennium Development Goals shaped the global health agenda, provided a focus for increased aid funding and contributed to some major improvements in health outcomes.[241] Much of the debate about the post-2015 development goals that will replace them focuses on whether universal health coverage (UHC), that everyone who needs health services is able to get them without incurring financial hardship, should be a headline priority. We argued that it should be in our January 2013 Report on *Post-2015 Development Goals*.[242] In that Report, we also called for women's health to be explicitly set out in the post-2015 framework.[243]

93. Though it supports UHC, DFID has argued for an outcome-based health goal, which it suggests would have a greater galvanising effect.[244] The latest draft post-2015 development goals include an overarching objective to "attain healthy life for all at all ages", with nine accompanying targets. One of these targets is to "achieve UHC, including financial risk

237 Q10 [Dr Andrew Cassels]

238 HSS23 [Oxfam] and HSS34 [International HIV/AIDS Alliance]

239 HSS51 [ICAI]

240 Q114 and Q119 [Lynne Featherstone MP]

241 Q8 [Dr Andrew Cassels] and Q55 [Dr Julian Lob-Levyt]

242 International Development Committee, Eighth Report of Session 2012–13, *Post–2015 Development Goals*, HC 657 para 47

243 Ibid, para 61

244 Q145 [Lynne Featherstone MP]

protection, with particular attention to the most marginalised and people in vulnerable situations".[245]

94. We heard concerns about targeting UHC, including that by encompassing entire populations it could lead to reduced focus on the poorest and most vulnerable, that it is a moving target as quality standards or population characteristics change, that it is too distant a prospect in some countries, and that it could lead to an over-emphasis on inefficient and ineffective insurance schemes.[246] However, we were also told that aiming for universal health coverage would necessitate HSS, as it was impossible to achieve without an effective health system and a long-term, cross-sector approach.[247] A UHC target could be a "critical mechanism for improving health system performance".[248] DFID concurred with this assessment, stating both that UHC would not be attained without strong health systems and that the NHS gave the UK a comparative advantage in working towards its achievement.[249]

95. ***We recommend DFID continue to press for universal health coverage as a prominent feature of a single post-2015 development goal for health.*** **Universal health coverage cannot be attained without a properly functioning health system. Its incorporation in post-2015 goals would add considerable impetus to health system strengthening efforts. Given DFID's systems expertise and the unrivalled experience of the NHS, this would put the UK in a position of even greater influence and responsibility. Should universal health coverage be targeted, DFID must be willing to grasp the opportunity it provides and demonstrate genuine world leadership on health system strengthening.**

245 UN Sustainable Development Knowledge Platform, *Introduction to the Proposal of the Open Working Group for Sustainable Development Goals*, July 2015, target 3.7

246 HSS15 [Malaria Consortium], HSS1 [GSK], HSS41 [Michael King and Elspeth King] and HSS23 [Oxfam]

247 For example, HSS15 [Malaria Consortium], HSS22 [Action for Global Health], HSS28 [Royal College of General Practitioners, HSS29 [Save the Children] and HSS27 [GRM Futures Group International]

248 HSS37 [Sightsavers]

249 HSS19 [DFID]

Conclusions and recommendations

DFID's health systems work

1. System strengthening is fundamental to the improvement of health outcomes. It is also the route to self-sufficiency for developing countries. We commend DFID for its strong focus on health system strengthening in its bilateral programmes. It is important that health outcome targets do not have the unintended consequence of reducing this focus. *We recommend DFID review its health targets to ensure that they are compatible with achieving its system strengthening objectives.* (Paragraph 12)

2. Despite some significant moves in the right direction, we are not convinced that DFID's main international partners give the development of health systems the same priority as DFID does. To some extent, this is understandable; multilaterals such as the Global Fund and GAVI were set up to tackle particular diseases, tasks they have performed with great distinction. But DFID now has fewer bilateral programmes and relies on multilaterals to manage an ever-greater proportion of its expenditure, often without in-country representatives. *We recommend that DFID conduct a detailed assessment, by country, of the extent to which existing funding arrangements enable its health systems strengthening objectives to be met.* (Paragraph 19)

3. DFID expresses continued support for the International Health Partnership (IHP+), but it is not providing the impetus for increased coordination it did in the past. *We recommend DFID reaffirm its commitment to IHP+ by publishing on an annual basis the steps it is taking to implement, and encourage its international partners to adopt, IHP+ principles and recommended behaviours.* (Paragraph 26)

Information and accountability

4. It is impossible to know how well DFID is delivering its health systems strengthening strategy without knowing how much it spends or having indicators of its performance. Nor can DFID allocate its resources efficiently in the dark. These deficiencies are best addressed through the publication of data to internationally-agreed standards. This would ensure comparability and enable DFID to exert influence on its partners to improve their system strengthening work. *We recommend that DFID prioritise international agreement on measures of system strengthening expenditure and efficacy as part of discussions about the post-2015 development goals. We further recommend that, once agreed, these measures form part of DFID's regular reporting.* (Paragraph 31)

5. The Global Fund and GAVI have been highly successful in improving health outcomes in some of the poorest parts of the world. The multilateral model has advantages in economies of scale. However, it is unacceptably difficult to assess whether these organisations have genuinely and sufficiently switched focus to system strengthening. The multilaterals and their donors have a responsibility ensure that their assistance has the greatest possible impact. DFID has a responsibility to UK taxpayers to ensure that their money can be followed and is spent wisely. We recommend that DFID insist that the Global Fund and GAVI publish better

measures of system strengthening expenditure and performance. If DFID is not satisfied that system strengthening is being given sufficient priority by an organisation, and that organisation does not change, DFID should be prepared to withhold funds. *We further recommend that DFID press the Global Fund and GAVI for programme data to be published online. Freely accessible data will facilitate more accountability and scrutiny, and should also be of benefit to systems strengthening research.* (Paragraph 35)

6. Other donors do not share DFID's responsibilities to UK taxpayers. Private donors such as the Gates Foundation are rightly free to set their own priorities. However, health development is invariably a complex team effort. Transparency about expenditure and performance is imperative for these arrangements to work well. *We recommend that DFID work harder to encourage its partners to make more data on their health systems strengthening work freely available.* Accepting our recommendation that it publish more disaggregated statistics of the expenditure and performance of its own programmes would set a good example and make this task easier. (Paragraph 36)

7. Understanding what works is an important part of effective and efficient intervention in health systems. At the moment, too little is known. DFID has a large research budget and allocating more of it to health systems is likely to be good value for money. *We recommend that DFID increase funding for health system strengthening research.* (Paragraph 39)

Foundations of strong health systems

8. The lack of progress by many African governments on the health expenditure commitment in the 2001 Abuja declaration is very worrying. It suggests a culture of reliance on aid that is irreconcilable with ultimate self-reliance. DFID aid should never be a blank cheque. *We recommend that, as well as making the positive case for expenditure on health systems, DFID work with developing country governments to agree medium-term aid plans based on concordance with the Abuja target and fund accordingly, taking a tough line with governments which are unwilling to take responsibility for the long-term health of their own populations. We also recommend that DFID make better use of local parliamentarians and medical professionals as advocates for prioritising expenditure on health systems over other demands.* (Paragraph 54)

9. Health systems governance and finance are complex political issues. The outcomes of intervention in these areas tend to be uncertain and expenditure on them can be harder to sell to electorates, donors and developing country governments. DFID's international partners, given their narrower objectives, are also less likely to be involved. However, health systems governance and finance are vital to properly functioning and ultimately self-sustaining health systems. DFID must lead the way on strengthening them, including making the case for such interventions to sceptics at home and abroad. (Paragraph 55)

10. The staffing of the UK health sector should not be at the expense of health systems in developing countries. We recommend DFID work with the Department of Health to

review its approach to the UK recruitment of health workers from overseas. This review should consider options for compensating source country systems, promoting training schemes that involve a temporary stay in the UK, and strengthening local programmes to enable more medical training to take place in-country. (Paragraph 60)

11. Doctors, nurses and other health professionals are at the centre of any well-functioning health system. We are concerned that DFID does not know how much it spends on human resources for health and or have means of monitoring its performance. *We recommend that DFID's review of its approach to human resources for health extends to an ambitious strategy which would set an example of best practice to international partners.* (Paragraph 62)

12. Community health workers can be an important part of a developing health system. They provide flexibility and enable programmes to be scaled-up very quickly. However, they should not be seen as an easy remedy for all health system problems, nor as a substitute for properly trained and specialist health professionals. As in other areas, DFID would benefit from sounder monitoring and a better evidence base in assessing the role to be played by community health workers in individual countries. (Paragraph 66)

13. Community services and public health are important parts of an effective and efficient health system. There can be a tendency, driven partly by standard health system models, to focus on curative care in formal national systems. We heard concerns that DFID sometimes falls into this trap. It is too hard to assess whether this is the case. *We recommend that, in publishing the disaggregated data recommended earlier in this Report, DFID prioritise community services and public health.* (Paragraph 74)

14. DFID rightly identifies factors ranging from superstition and mistrust of formal health systems to discrimination and violence against women and girls as obstacles to improving healthcare. *We recommend that DFID press its international partners, including national governments, to tackle unacceptable cultural barriers to access to health services.* (Paragraph 75)

Making better use of NHS expertise

15. Volunteering overseas by UK medical staff can be highly advantageous for developing health systems. Through the personal and professional development of individuals, the sharing of best practice and the building of global contacts, it can also be of great benefit to the NHS. Existing volunteering schemes, though often successful, are small-scale and fragmented. The Health Partnership Scheme is highly effective, but its funding is a drop in the ocean. Volunteering schemes need coordination, structure and scaling up. (Paragraph 82)

16. NHS staff should be supported in seeking to apply their skills where need is greatest. *We recommend that the new NHS framework for volunteering establishes a formal structure to facilitate the participation of many more medical professionals, including through extended sabbaticals, and makes clear that volunteering overseas is valued*

and consistent with career progression. DFID should provide the necessary funds to support these more ambitious schemes. We further recommend that DFID investigates means of supporting those who volunteer, including continuing NHS pension contributions and paying down student loans. (Paragraph 83)

17. Demand for NHS staff does not end with doctors and nurses. Though often criticised at home, the NHS is held in high international regard and many countries would greatly benefit from the assistance of those expert in managing and financing such a successful health system. In turn, NHS managers would benefit from tackling familiar problems in unfamiliar settings. This is a challenge to traditional development models and DFID must be sufficiently agile to adapt to changing and increasingly complex needs. NICE International is a successful example of how NHS expertise can benefit overseas systems, and leverage funds from other donors in the process. *We recommend that DFID establish a clear strategy for how UK government should work in partnership with the NHS to support overseas health systems.* (Paragraph 86)

DFID leadership

18. DFID's own health systems strengthening work is world-leading. But that is not enough; DFID must be an active and vocal systems champion, driving the international agenda by experience and example, pressing other donors to prioritise systems strengthening and exercising its influence on the boards of multilaterals to ensure that they have genuine systems focus at strategic level. As it is, DFID, and its ministers in particular, are insufficiently vocal. This is a particular concern in the increasing number of countries where DFID does not have a bilateral programme. *We recommend that DFID publish a clear health strategy, including measures of performance, setting out the rationale for system strengthening, how it intends to strengthen systems in its own work and what it expects from its international partners.* (Paragraph 91)

19. *We recommend DFID continue to press for universal health coverage as a prominent feature of a single post-2015 development goal for health.* Universal health coverage cannot be attained without a properly functioning health system. Its incorporation in post-2015 goals would add considerable impetus to health system strengthening efforts. Given DFID's systems expertise and the unrivalled experience of the NHS, this would put the UK in a position of even greater influence and responsibility. Should universal health coverage be targeted, DFID must be willing to grasp the opportunity it provides and demonstrate genuine world leadership on health system strengthening. (Paragraph 95)

Formal Minutes

Tuesday 2 September 2014

Members present:

Sir Malcolm Bruce, in the Chair

Sir Tony Cunningham	Fabian Hamilton
Jeremy Lefroy	Sir Peter Luff

Draft Report, *(Strengthening health systems in developing countries)* proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 95 read and agreed to.

Annex and Summary agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjourned till Tuesday 14 October at 10.00 am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at Strengthening health systems in developing countries

	Question number
Tuesday 24 June 2014	
Dr David Evans, Director of Health Systems Governance and Financing, World Health Organization, **Dr Andrew Cassels**, Senior Fellow, Global Health Programme, **Professor Kara Hanson**, Head of Global Health, London School of Hygiene and Tropical Medicine	
Dr Julian Lob-Levyt CBE, Senior Vice President, International, DAI, former CEO, GAVI Alliance, and former Health Adviser, Department for International Development, **Lord Crisp KCB**, and **Simon Wright**, Head of Child Survival, Save the Children UK, on behalf of Action for Global Health.	Q1-56
Thursday 10 July 2014	
Dr Kalipso Chalkidou, Director, NICE International, **Dr John Howard**, Chair, International Forum of the Academy of Medical Royal Colleges, and **Dr Michael Johnson**, Head of Technical Advice and Partnerships, the Global Fund to Fight AIDS, Tuberculosis and Malaria	
Lynne Featherstone MP, Parliamentary Under Secretary of State, Department for International Development, **Jane Edmondson**, Head of Human Development Department, DFID, and **Angela Spilsbury**, Senior Health Adviser based in Ethiopia, DFID	Q57-148

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at Strengthening health systems in developing countries. HSS numbers are generated by the evidence processing system and so may not be complete.

1 GSK (HSS0001)
2 NICE International, National Institute for Health and Care Excellence (HSS0002)
3 Fernhealth Project, University of Aberdeen (HSS0003)
4 Riders for Health (HSS0005)
5 Options Consultancy Services Ltd (HSS0006)
6 Overseas Development Institute (Dr Fiona Samuels) and Dr Dina Balabanova (HSS0007)
7 London School of Hygiene and Tropical Medicine (HSS0008)
8 Royal College of Physicians (HSS0009)
9 Mrc Clinical Trials Unit at UCL (HSS0010)
10 Future Health Systems (HSS0011)
11 The Open University
12 Tony Blair Faith Foundation (HSS0013)
13 Reachout Consortium (HSS0014)
14 University of Cape Town (HSS0015)
15 Malaria Consortium (HSS0016)
16 Dr Dina Balabanova and Professor Martin McKee (HSS0017)
17 VSO (HSS0018)
18 Royal College of Physicians of Edinburgh (HSS0019)
19 DFID (HSS0020)
20 Crown Agents Limited (HSS0021)
21 Medicines for Malaria Venture (HSS0022)
22 Action for Global Health UK (HSS0023)
23 Oxfam GB (HSS0024)
24 Oxfam Zambia (HSS0025)
25 Results UK (HSS0026)
26 Marie Stopes International (HSS0027)
27 GRM Futures Group (HSS0029)
28 Royal College of General Practitioners (HSS0031)
29 Save the Children (HSS0032)
30 Stopaids (HSS0033)
31 Gavi Alliance (HSS0034)
32 Age International and Helpage International (HSS0035)
33 World Bank Group (HSS0036)
34 International HIV/Aids Alliance (HSS0037)
35 International Committee of The Red Cross (HSS0038)
36 Wellcome Trust (HSS0039)
37 Sightsavers (HSS0040)
38 Sightsavers Annex A (HSS0041)

39 International Rescue Committee (HSS0042)
40 Bill & Melinda Gates Foundation (HSS0043)
41 UK Coalition Against Neglected Tropical Diseases (HSS0044)
42 Michael King OBE and Mrs Elspeth King Ph.D (HSS0045)
43 Health Poverty Action (HSS0046)
44 Sarah Colenbrander (HSS0047)
45 Dr Julian Lob-Levyt CBE (HSS0048)
46 Dr David Evans (HSS0049)
47 Rebulid Consortium (HSS0050)
48 THET (HSS0051)
49 Mott Macdonald/HLSP (HSS0052)
50 Global Fund to fight AIDS, Tuberculosis and Malaria (HSS0053)
51 Department for International Development Annex A (HSS0054)
52 Department for International Development Annex B (HSS0055)
53 Save the Children (HSS0056)
54 Sightsavers Annex B (HSS0057)
55 Public Health England (HSS0058)
56 Independent Commission for Aid Impact (HSS0059)
57 THET Annex A (HSS0060)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/indcom.

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2014–15

First Report	UK Support for Humanitarian Relief in the Middle East	HC 248
Second Report	Scrutiny of Government's UK Strategic Export Controls Annual Report 2012, the Government's Quarterly Reports from October 2012 to September 2013, and the Government's policies on arms exports and international arms control issues	HC 186
Third Report	The UK's Development Work in the Occupied Palestinian Territories	HC 565
Fourth Report	The Independent Commission for Aid Impact's Performance and Annual Report 2013-14	HC 523

Session 2013–14

First Report	Global Food Security	HC 176 (626)
Second Report	Violence Against Women and Girls	HC 107 (624)
Third Report	Scrutiny of Arms Exports and Arms Control (2013): Scrutiny of the Government's UK Strategic Export Controls Annual Report 2011 published in July 2012, the Government's Quarterly Reports from October 2011 to September 2012, and the government's policies on arms exports and international arms control issues	HC 205 (CM 8707)
Fourth Report	Multilateral Aid Review	HC 349 (694)
Fifth Report	ICAI's Annual Report 2012-13	HC 566 (946)
Sixth Report	Implications for development in the event of Scotland becoming an independent country	HC 692
Ninth Report	Democracy and Development in Burma	HC 821
Tenth Report	Department for International Development's Performance in 2012-13: the Departmental Annual Report 2012-13	HC 693 (522)
Eleventh Report	Disability and Development	HC 947 (336)

Session 2012–13

First Report	DFID's contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria	HC 126 (609)
Second Report	Scrutiny of Arms Exports (2012): UK Strategic Export Controls Annual Report 2010, Quarterly Reports for July to December 2010 and January to September 2011, The Government's Review of arms exports to the Middle East and North Africa, and wider arms control issues	HC 419 (CM 8441)
Third Report	The Development Situation in Malawi	HC 118 (641)
Fourth Report	Tax in Developing Countries: Increasing Resources for Development	HC 130 (708)
Fifth Report	DFID's programme in Zambia	HC 119 (759)
Sixth Report	Afghanistan: Development progress and prospects after 2014	HC 403 (862)
Seventh Report	UK Aid to Rwanda	HC 726 (949)
Eighth Report	Post-2015 Development Goals	HC 657 (1065)
Ninth Report	Department for International Development's Annual Report and Accounts 2011–12	HC 751(1098)
Tenth Report	Pakistan	HC 725

Session 2010–12

First Report	Appointment of the Chief Commissioner of the Independent Commission for Aid Impact	HC 551
Second Report	The 2010 Millennium Development Goals Review Summit	HC 534 (HC 959)
Third Report	Department For International Development Annual Report & Resource Accounts 2009–10	HC 605 (1043)
Fourth Report	The World Bank	HC 999 (1044)
Fifth Report	The Future of CDC	HC 607 (1045)
Sixth Report	Scrutiny of Arms Export Controls (2011): UK Strategic Export Controls Annual Report 2009, Quarterly Reports for 2010, licensing policy and review of export control legislation	HC 686 (CM 8079)
Seventh Report	The Humanitarian Response to the Pakistan Floods	HC 615 (1435)
Eighth Report	The Future of DFID's Programme in India	HC 616 (1486)
Ninth Report	DFID's Role in Building Infrastructure in Developing Countries	HC 848 (1721)
Tenth Report	The Closure of DFID's Bilateral Aid Programme in Burundi	HC 1134 (1730)
Eleventh Report	Financial Crime and Development	HC 847 (1859)
Twelfth Report	Working Effectively in Fragile and Conflict–Affected States: DRC and Rwanda	HC 1133 (1872)
Thirteenth Report	Private Foundations	HC1557 (1916)

Fourteenth Report	Department for International Development Annual Report and Resource Accounts 2010–11 and Business Plan 2011–15	HC 1569 (107)
Fifteenth Report	South Sudan: Prospects for Peace and Development	HC 1570 (426)
Sixteenth Report	EU Development Assistance	HC 1680 (427)