Memo

Deepening UK Partnership for Value for Money in Developing Country Health Systems
Report of a Meeting at the Center for Global Development, London, UK
21 March 2016

Key points
- The UK has a strategic interest and comparative advantage in value for money in health.
- There is both need and demand to enhance the value for money of developing country health systems, and to assure value for money in aid investments as well.
- Existing mechanisms fail to provide an integrated and coherent offer to developing countries and to aid agencies.
- Meeting participants discussed how a dedicated value for money partnership—with public and private involvement—might be mobilized to respond to needs and integrate offers.
- Different organisational models were considered, and a full options analysis to build a dedicated partnership may represent a sensible next step.

The background

Value for money is at the core of UK values across the political spectrum and over time. Cameron: “we need absolute clarity on what government should prioritise in an era of obviously finite resources. To govern is to choose – and we have made clear choices, so we will give the NHS the resources it needs. And compared with 2014, that means a real terms increase of £10 billion a year by 2020 to support the NHS in delivering its own Five Year Plan – while all the time getting the best value for money from that spending.” In 2015, Justine Greening highlighted DFID’s commitment to “a laser-like focus on better results and achieving much greater value for taxpayers’ hard-earned money.” The 2015 All-Party Parliamentary Group on Global Health report The UK’s Contribution to Health Globally has noted the significant comparative advantage of UK institutions. Matt Ridley has noted: “health will be the booming industry of the 21st century and we need to cash in on our expertise in so many areas.”¹

The UK’s institutions set up to enhance the value for money of public spending on health are admired around the world: NICE, NHS and NAO are sought out by countries poor and rich for the expertise in measuring, assessing and reforming to enhance the value for money of health investments and other kinds of public spending. Another equally important dimension of efficiency is being efficient in securing fair distribution of health care resources

¹ http://www.thetimes.co.uk/tto/opinion/columnists/article4482375.ece
and financial protection from catastrophic health care expenditures. Equity and distributional concerns are at the heart of the NHS, a core expertise of NHS institutions and no less important than efficiently provided interventions.

NICE International has worked in over 40 countries over the past 8 years, raising over $20m in grants and contracts for technical assistance. It is currently advising the governments of India, Vietnam, Mexico, Indonesia, Ghana and South Africa on how to improve the value of their healthcare investment and protect people from impoverishment through smart technology adoption decisions as well as enhancing the quality of services through implementable and enforceable regulatory standards.

This expertise is not only in government: the UK’s consulting and information technology industry incl. the BMJ Group, the Economist Intelligence Unit and Capita, have a growing global presence in healthcare in emerging markets, generating the potential for synergies with the UK’s NHS.

Equally strong and with a global footprint, UK Universities, at home and abroad, train thousands of overseas students every year, producing influential alumni, and carry out ground-breaking research in basic science, clinical medicine and social sciences.

A whole-of-government expertise and approaches are needed to assure policy coherence in the UK’s engagement with low- and middle-income countries, with UK Institutions leading long-term partnerships, playing a significant role, as set out in the government’s 2015 manifesto commitment.

The need

Between 20-40% of the $7.1 trillion spent annually on healthcare is wasted.\(^2\). Development assistance for health makes up less than 1% of this (~$36bn)\(^3\) – and if global health gains are to be made –as codified in the recently-endorsed Sustainable Development Goals- aid must leverage greater efficiency of spending in low- and middle-income countries themselves.

While aid agencies charged with spending on behalf of the UK have made efforts to support cost-effective investments in general terms, their approach has lacked rigor when it comes to actual purchasing and provision decisions and advice, with consequences for the efficiency and human impact of spending in the very poorest countries in the world. Further, they are inconsistent with UK domestic policies on public spending. For example:

- New vaccines selected for subsidy by Gavi are not screened for cost-effectiveness in the low-income health systems into which they will be introduced\(^4\) and illustrate a fundamental misunderstanding of the meaning of value for money by considering costs and benefits separately and using a color-coded scale rather than analysis of incremental cost-effective ratios and best practice in economic evaluation;

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\(^4\) [http://www.gavi.org/about/strategy/vaccine-investment-strategy/](http://www.gavi.org/about/strategy/vaccine-investment-strategy/)
• Products purchased by the Global Fund to fight AIDS, TB and Malaria are not selected based on cost-effectiveness criteria\(^5\); and

• World Health Organisation clinical guidelines are based on expert opinion rather than cost-effectiveness and affordability analyses.\(^6\)

Value for money also matters for public health emergencies like Zika and Ebola too. As in earlier experiences with treatments like Tamiflu and Relenza in response to flu outbreaks, it is easy to feel overwhelming political and public pressure to expand purchase of medicines and vaccines that may or may not represent value for money. Assuring a rigorous approach to deciding on best response given effectiveness and costs is essential.

Developing countries’ budgets and healthcare expenditure are growing, but demands on those budgets are growing too, both from expensive new technologies and an expanding base of citizens entitled to accessing care in the context of Universal Healthcare Coverage. Countries have limited capacity to prioritise health across sectors, and within it, make a case for targeted investments so that return on investment is maximised and distributional trade-offs quantified and managed. The result can be inefficiencies and inequities\(^7\) affecting health outcomes as well as economic growth and political stability.

Further, transitioning the relationship between the UK and rapidly-growing middle-income countries away from aid and towards trade and other kinds of cooperation depends vitally on those countries’ abilities to set cost-effective priorities for their own public monies and to assure fairness, transparency and a level playing field and on the UK’s ability to put forward a flexible offer, spanning philanthropy for the poorest states, to smartly phased co-financed technical cooperation for emerging powers with large number of poor, to competitive for-profit consultancy to established economies or the growing private sectors of middle income markets.\(^8\)

**Response to date**

Thus far there has been only small-scale institutional, technical and data gathering support for improving resource allocation for UHC in developing countries, a gap in the international landscape that is dominated by disease-specific initiatives (that in themselves require attention to UHC and value for money issues in order to be successful and sustainable). A new emphasis on process and governance for making fair, transparent, evidence-informed resource allocation decisions is a prerequisite for fulfilling the global community’s commitment to fighting corruption and reducing waste of valuable and overstretched overseas aid monies and national healthcare budgets.

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\(^5\) [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3848836/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3848836/)


Countries are increasingly articulating their need for technical cooperation and win-win partnerships on equal terms as opposed to one way and one-off technical assistance projects. Indeed, as demonstrated by the findings of the recent APPG report on the UK’s global health footprint, the IDC’s enquiry into and recommendations on HSS, numerous bilateral government to government agreements to work on HSS, last year’s UK-China People to People dialogue and the joint statement following the recent visit by PM Modi to the UK, requests for accessing UK expertise are mounting.

The requests are not limited to emerging economies. Earlier this month (March 2016), the government of Ethiopia officially requested access to NHS expertise on value for money, regulatory strengthening and health financing. Similar requests have been received from the newly elect government of Myanmar. Ghana’s Ministry of Health is seeking assistance through DFID for improving the affordability of its Benefits Package in the context of an ongoing Presidential Review of the scheme. Moreover, entities receiving billions from the UK such as the Global Fund and UNITAID are also now reaching out to the UK for support with assessing the value for money of investment decisions in emerging technologies. Interestingly, the BMGF also commissioned UK institutions such as NICE International and its partners (www.idsihealth.org) and university departments of economics specializing in measuring value for money of health spending, to set out clearer rules amongst its own grantees as to how to measure and achieve better value for money.

Current challenges

But the current situation is far from conducive to realizing the potential for multiple wins as countries transition towards better health and equity and the UK benefits from its global engagement in terms of soft power, trade and philanthropy.

To start with, articulating demand, putting it forward to HMG and sourcing appropriate expertise poses a unique challenge to foreign governments and payers. A recent assessment has found evidence of high demand channeled to state, commercial and academic organisations, yet “it was unclear how to respond.”

➢ There is a need for a better matchmaking function between demand and supply informed by an up to date mapping of both.

Current incentives for UK government agencies to undertake and coordinate international work are in place, but could strengthened by adding targets set by Home Secretary (or Treasury) to meet international value for money goals that require cooperation with LMIC.

➢ There needs to be a clear signal alongside an accountability framework across HMG and public sector bodies that international partnerships matter as does sharing their expertise with overseas counterparts in the context of the broader “UK Institutions” agenda.

There is a significant pressure across the public sector and NHS ALBs to cut operating costs and reduce headcount, concentrate on domestic work and only develop an international presence in order to income generate in the short term. In this climate, even self-sustaining international functions such as NICE International, are being challenged and scaled down or

refocused towards more commercial objectives. At the same time, there are reputational risks from forging ahead with a short-termist commercial agenda on the back of bilateral relationships with major allies such as Mexico, South Africa and India.

- Dedicated funding and dedicated functions may be required for UK Institutional partnerships in high demand areas such as Value for Money, to materialise in the current financial climate. The Prosperity Fund offers a unique opportunity to fund such functions.

The lack of coordination across government agencies and across state/non-state/private sector groups, is resulting in a lack of a consolidated UK offer, compounded by duplication of effort and mixed messages. There are anecdotes of four Royal Colleges approaching a single MIC, with different messages and support, sometimes conflicting; or of commercial arms of government asking for payment from foreign government officials on the back of MOUs or projects already funded by non-UK sources.

- A dedicated coordinating function, plugged into government and the public sector but independent of both, with a social mission and strong philanthropic, research and commercial skills, should be established, perhaps funded by the Prosperity Fund, to ensure the UK’s offer is appropriately tuned and targeted.

This government is committed to enhancing the value for money of its own aid, be it channeled through multilaterals such as the Global Fund or through other government departments.

- A dedicated function can independently inform ODA investment decisions, drawing on a dedicated M&E framework and related Theory of Change, encompassing commercial, diplomacy and more conventional aid objectives.

**The opportunity**

To respond to the need and challenges, ideally, there would be a mechanism for expressing, consolidating and responding to developing country demand for technical support whilst making it easier to find out what is on offer from UK, in terms of capabilities but also capacity and willingness to engage given the tight budgets and resource constraints the service is facing domestically.

This, in turn, necessitates a whole of government,
politically coherent and beyond aid (to encompass foreign policy and trade objectives) approach. The latter must include key HMG departments such as the Cabinet Office, DH/PHE, DFID, Treasury and FCO as well as non-departmental bodies and independent agencies such as NICE, the British Council and NAO, professional organisations (Royal Colleges), universities and entities operating at the interface of the NHS and academe (e.g. Academic Health Science Networks), UK journals, private players and UK NGOs (e.g. Save the Children).

The effort could build on the well-established and initially-resourced International Decision Support Initiative (IDSI), currently led by NICE International, with a strong network of domestic and international institutions, strong support from major funders such as the Bill & Melinda Gates Foundation, a track record attracting DFID funds, and an ongoing role in servicing HMG’s global health diplomacy objectives. IDSI can coordinate other UK technical partners to articulate an integral offer of expertise in value for money, using its current funding as a seed for setting up and growing deeper partnership.

Possible models

One option is an NGO-type entity with a governance model which allows for the NHS/NICE brand to be maintained and for the reputational and other benefits to continue to accrue to HMG, whilst controlling for potential risks through a Board with HMG and NHS participation, and with the potential of additional paying members from the global development and CSR worlds as well as select major partner governments with a minority stake (e.g. Thailand).

Another option might be based on the experience of the Behavioural Insights Team, with, for example, a similar retainer contract for servicing the needs of government departments committing ODA, as well as the ability to grow flexibly, without public procurement and accounting rules or HR constraints, and to service private sector clients. For the latter to work, a social responsibility company/community interest company, may have to be set up, owned by the Partnership and locking into the latter’s mission the value it generates through commercial activities.

Tapping into broader NHS as well as British academic expertise through joint ventures between academia and frontline NHS such as Academic Health Science Centres and their network (http://www.ahsnnetwork.com/) may be another way of harvesting British know-how.

Financing sources may include HMG ODA from DFID and other department as required based on the priority countries, as well as philanthropic and research grants, and fees from paying clients, development bank contracts, and CSR and social impact investment and paying Board members (minority stake). A tiered pricing policy may look like this:

- Philanthropic funding through foundations, bilaterals including DFID and other UK government departments spending ODA, and major funding conduits (GF, GAVI, WB) for LICs/LMICs
- DH ODA for global health diplomacy in countries that are high priority for HMG but are not DFID priority countries (e.g. AMR in China and India using quality and efficiency interventions as an entry point)
- Phased co-financing for emerging powers through (BRICS – incl. targeting the world’s poorest populations living in MICs)
- For profit fee schedule through social enterprise with profits fed back to partnership vehicle (e.g. Singapore, cities of Shanghai and Sao Paolo, private insurers in BRICS with positive externalities for public purchasers re data and regulatory framework as well as OOP/private spending)
- CSR and social impact investment can also be explored as revenue sources and early indications of interest are positive.
- This is an opportunity to explore alternative models and set a model in aid sustainability vehicles – e.g. “profit with purpose” models as championed by the G8 under the UK’s Presidency

Current opportunities for immediate impact:

There are existing opportunities for immediate action, but that have not had a response due to the absence of the kind of mechanism under consideration. For example:

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• Offer for partnership with major consultancy to build Singapore health technology assessment (HTA) capacity hub servicing needs of product manufacturers, payers and national governments in SE Asia with significant Sovereign Fund early stage subsidy;
• Request for institutional support with HTA under the NHIS in the Bahamas, similar requests from government of Singapore;
• Specific request for technical support with purchasing of new generation malaria nets or fever diagnostics from Global Fund; ongoing discussion regarding support with evidence informed purchasing of UNITAID pipeline products with significant potential for gains for UNITAID and Global Fund funders including the UK government;
• Opportunity for country level partnership with CHAI in select LICs for total system reform over 10 year horizon;
• Ongoing partnership with Mexican government with IADB support
• Prosperity Fund application together with Capita and China government co-financing for electronic pathways for managing NCDs in public hospitals; similar prosperity fund projects in Chile and India (scoping stage)
• Ongoing delivery (with no/limited direct financial support) for UK DH, on bilateral MOUs with Mexico, South Africa, China and India
• Partnership with FCO Economic Diplomacy Unit with emphasis on BRICS and build on People to People China UK dialogue and Indian PM State visit with NICE Intl major implementing partner in both sets of action plans in healthcare

**Next steps**

The consultation meeting has yielded specific recommendations to establish a deepened UK partnership around value for money and UHC with LMIC. A sensible next step is a deeper options analysis for a dedicated mechanism for UK partnership on value for money and UHC. However, any next step will require a mandate from HMG leadership and agencies to move forward.