House of Commons
International Development Committee

Strengthening Health Systems in Developing Countries: Government Response to the Committee's Fifth Report of Session 2014–15

Sixth Special Report of Session 2014–15

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The International Development Committee

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Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), Chloe Challender (Senior Committee Specialist), Louise Whitley (Committee Specialist), Zac Mead (Senior Committee Assistant), Paul Hampson (Committee Support Assistant) and Jessica Bridges-Palmer (Media Officer).

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Sixth Special Report

On 12 September 2014 the International Development Committee published its Fifth Report of Session 2014–15, Strengthening Health Systems in Developing Countries, HC 246. On 10 November the Committee received a memorandum from the Secretary of State for International Development which contains a response to the Report. The memorandum is published as an appendix to this Report.

Government response

Introduction

The UK Government welcomes the opportunity to respond to this timely report from the International Development Committee on Strengthening Health Systems in Developing Countries. The Government appreciates the report’s recognition of the UK’s longstanding good reputation for health system strengthening and of the high quality of bilateral support provided by the UK in partner countries.

Supporting countries to strengthen their health systems remains a top priority for DFID’s health work. A strong health system is one that delivers good quality essential services to all people, when and where they need them. The knowledge and the technologies already exist to prevent or treat many of the conditions that affect poor people and prevent the MDGs from being achieved, but weak health systems mean that many people, especially the poorest and most marginalised people, do not get good quality essential health care and so continue to suffer poor health.

Strong health systems are vital for making sure that improvements in health can be sustained in the long term and for ensuring that countries can cope with future challenges such as population growth, ageing, the increase in non-communicable diseases and crises such as the current Ebola epidemic.

Developments at the global level are raising the profile of health system strengthening internationally. There is growing consensus that countries should aspire to achieve universal health coverage, meaning that all people can use good quality essential health services when they need them, without the risk of financial hardship. This requires that good quality health facilities be in place, fully staffed with well trained and motivated staff, with working equipment and reliable stocks of commodities, and that the system be well managed, using good information, responsive to people’s needs and with consistent financing raised in efficient and equitable ways. This is precisely what health systems strengthening sets out to achieve.

DFID’s future work on health systems strengthening will need to be set within this changing international context, including the goals that will replace the Millennium
Development Goals (MDGs), which have yet to be finalised, and the Financing for Development agenda. Last year DFID published a Health Position Paper, which set out the UK’s public health approach to improving health outcomes in developing countries. This approach combines investments that achieve targeted results with investments that strengthen broader health systems. The next step will be to develop a framework for future work on health systems, which will be set within the context of broader global processes and will address measurement issues, build on the UK’s existing review of support for human resources for health and include how DFID works with the NHS and other parts of the Government.

Response to the conclusions and recommendations
[Note that the recommendations and responses are grouped in a different order to that in the Committee’s report.]

Information and accountability

Recommendation 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.

Agree

In individual programmes, DFID measures changes in health system performance directly using indicators such as the frequency of stockouts of essential drugs or the percentage of health facilities offering appropriate emergency obstetric care. Across DFID as a whole, however, success in health is currently measured in terms of indicators that reflect improvement in health outcomes, since this is the ultimate objective of all the UK’s health work, including systems strengthening.

Most of DFID’s current health targets have their end dates in 2015, in line with the MDG timeframe. The process of agreeing new development goals and targets, and indicators for measuring progress towards them, provides an opportunity for DFID to review how it measures success. The increasing focus on universal health coverage (UHC) – ensuring that all people can use good quality essential health services when they need them without risk of financial hardship - is helping to draw global attention to health systems strengthening: without strong health systems, UHC will not be achieved anywhere in the world. DFID will ensure that global aspirations for health systems strengthening are well reflected in its health targets from 2015 onwards.

Recommendation 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.

Partially agree
The Government agrees with the desire to standardise the indicators used to measure health systems performance and to reduce the number of indicators in use. DFID is already working actively with the World Health Organization (WHO) and others in the international community to identify indicators that allow an assessment of the strength and effectiveness of a health system. These indicators will provide a measure of the efficacy of health systems strengthening interventions. The same process will generate indicators that can be used to assess progress towards post-2015 goals and targets, including a target on universal health coverage.

When the global set of core indicators for measuring health results is agreed, DFID will encourage its partner countries and organisations to draw on it when selecting indicators to monitor progress. DFID will do the same for monitoring its own programmes. The choice of measures for future regular reporting will therefore be influenced by the choice of post-2015 goals, targets and indicators.

The international process to standardise and streamline indicators of health results is not addressing the issue of measuring health systems strengthening expenditure. The standardised definitions and classifications for reporting on aid financing internationally are set by the Organisation for Economic Co-operation and Development’s (OECD) Development Assistance Committee (DAC) and are not part of the post-2015 process. Some early thinking has been done about what would be required to develop a common framework for tracking health systems strengthening expenditure. This would include development of a common understanding of which activities contribute to health systems strengthening, and hence which health expenditure should be classified as systems strengthening, and harmonisation of data across agencies to allow comparisons. There would also need to be a process to change the OECD DAC expenditure purpose codes. DFID is following these discussions and will engage with the process as it develops.

Recommendation 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.

**Partially agree**  
The Government agrees that community services and public health – including prevention and health promotion – are essential aspects of the health system. This extends beyond the health sector: there are opportunities to have a significant impact on health outcomes through support to healthy public policy and environments, for example through water and sanitation, nutrition and transport policy. The DFID health position paper sets out the UK’s public health approach and much of the coordination and leadership work that DFID is valued for in partner countries is around establishing and maintaining the links between different parts of the system. DFID also works with Public Health England to help share the benefits of UK experience and expertise with other countries.

The global set of core indicators on which DFID’s post-2015 reporting is likely to be based is close to finalisation and the current draft includes indicators of public health and community level services.

**Recommendation 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 to 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.

**Partially agree**  
The Government agrees that the Global Fund and Gavi\(^1\) should do better in measuring the impact and cost-effectiveness of their investments in system strengthening. DFID has worked with partners to include a Key Performance Indicator (KPI) of health systems strengthening in the Global Fund monitoring framework. The Fund will measure and report against this KPI to the board annually. DFID will now work with Gavi to develop an appropriate KPI on health systems strengthening for their new strategic period 2016-2010 for approval by the Gavi Board at their meeting in June 2015. This will also be measured and reported by Gavi on an annual basis.

\(^1\) Since the Committee's report was published, GAVI has changed its name to Gavi, the Vaccines Alliance.
DFID uses both organisations’ institutional KPIs in its own progress monitoring frameworks. This means that their progress on health systems strengthening is measured annually and contributes to the DFID Annual Reviews of these organisations, which in turn influence continued UK funding. A decision to withhold funding to Gavi or the Global Fund would have a significant impact in developing countries, given that both organisations deliver life-saving interventions to millions of people. Before making such a decision the UK would need to take into account performance in all areas and not just on systems strengthening.

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.

Agree
Both Gavi and the Global Fund already score highly on transparency relative to other donors. In the 2014 Aid Transparency Index Gavi was ranked fourth and the Global Fund tenth.

Both agencies publish data on their websites. The grant portfolio section of the Global Fund’s website includes a separate page for each country, with extensive financial and performance data on each of more than 1,000 grants it has made to date. Some of these grants are focused entirely on health system strengthening, while others include systems strengthening elements. Raw data about the Fund’s grant portfolio can also be accessed via the website.

Gavi also publishes data on health systems strengthening expenditure and progress by country and by grant on its website.

Recommendation 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.

Agree
DFID models good behaviour on transparency. Under the government’s transparency commitment, information is published each month about DFID’s expenditure and projects. All business cases, annual reviews, project completion reviews and evaluations are published on the Development Tracker. DFID also has an open and enhanced
access policy for research and evaluation. It has identified a leading data repository and is moving forward arrangements for submitting datasets with them. Once this is finalised, DFID will then require all researchers to make their data open access via this repository.

This high level of transparency has received international recognition: DFID was ranked second out of 68 donor organisations in the 2014 Aid Transparency Index. DFID will continue to set a good example to its partners on transparency and to encourage them to follow this example.

Strategies and working with the NHS

The responses to recommendations 18, 11 and 17 are combined below

Recommendation 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.

Recommendation 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.

Recommendation 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.
Agree

In August 2013 DFID published its Health Position Paper: Delivering Health Results. This paper sets out how DFID works to improve health outcomes in developing countries including DFID’s public health approach, which combines investments that achieve targeted results with investments that strengthen broader health systems.

Building on this paper, the UK’s work to date on human resources for health and broader processes including the development and agreement of post-2015 goals, targets and indicators, DFID will develop a framework for its work on health systems strengthening, which will set out areas of focus for work in developing countries and globally. The framework will encompass the global processes underway in the shift from the MDGs to the new development goals and will consider the implications for measurement of progress towards universal health coverage. It will also include DFID’s approach to working with the NHS and other UK government and non-government organisations.

Recommendation 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.

Agree

The Department of Health (DH) and DFID will continue to work together to review their approach to the UK recruitment of health workers from overseas.

In moving towards reducing the gap in healthcare workers DH endorses the WHO Global Code of Practice on the International Recruitment of Health Personnel and implements it through the UK Code of Practice for international recruitment. DH works closely with DFID on reviewing the definitive list of developing countries which should not be targeted for recruitment of healthcare professionals.

DH also continues to work with DFID, the lead department, to support the Health Partnership Scheme (HPS). The scheme aims to improve health outcomes in low-income countries through effective transfer of health services skills, in ways that also benefit the UK public health sector. It provides opportunities for British nurses, doctors and health workers to play a crucial role in the UK’s effort to reduce maternal and child deaths in the world’s poorest countries.

In addition, the DH and DFID continue to recognise the value of the Medical Training Initiative (MTI) and its importance in the way that the health sector supports the
Government’s international development objectives with doctors returning to their countries and applying the skills and knowledge developed during their time in the UK. Doctors benefiting from MTI training take back with them knowledge of practice, procedure, networks and UK expertise which deliver significant tangible benefits to the UK economy.

DFID will also continue to look at ways of supporting local medical training in its partner countries in order to promote retention of health workers. The UK already provides some support. HPS, for example, has contributed to health worker training including curriculum development in 26 countries using the skills of UK health professionals. Similarly, the ‘Making it Happen’ Partnership between the Royal College of Obstetricians and Gynaecologists and the Liverpool School of Tropical Medicine is training health professionals in Emergency Obstetric and Neonatal Care to reduce maternal and newborn mortality and morbidity in 11 countries in sub-Saharan Africa and South Asia. Decisions about any new funding will depend on future budgets and operational plans.

**Recommendation 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.**

**Partially agree**
DH recognises the numerous benefits in overseas volunteering by UK health professionals to contribute effectively to global health development through the Medical Training Initiative and the DFID-led Health Partnership Scheme.

DH has set up a working party to provide information to support potential volunteers in the NHS to take up volunteering positions. Membership of the working party includes DFID, the Tropical Health Education Trust, the British Medical Association, the Nursing Midwifery Council, NHS Employers and charities that volunteer overseas.

This group is looking at issues surrounding accreditation and continuing professional development and other barriers to volunteering. It will also examine the barriers and constraints that affect employers with a view to identifying best practice and exemplar activity within the service. A tool is being developed to help employees provide evidence of the benefits from volunteering and, in particular, how skills/knowledge gained will benefit the NHS.
Recommendation 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.

**Partially agree**

In response to the recent Ebola outbreak in West Africa, the Chief Medical Officer recently wrote to NHS staff encouraging them to volunteer to help in Sierra Leone. Over 650 NHS frontline staff and 130 Public Health England staff have volunteered to go out to Sierra Leone to help in the UK’s efforts on the ground.

DH will work with DFID, NHS England, the devolved administrations and the NHS International Health group to explore the feasibility of establishing a formal structure to support volunteering. The framework acknowledges the work of the DH-led volunteering overseas group on developing a tool to help employees provide evidence of the benefits from volunteering and, in particular, how skills/knowledge gained will benefit the NHS.

The DH volunteering group also acknowledged that volunteers returning from overseas face a much reduced pension. The working group has worked to maintain the continuity of contributory membership of the NHS Pensions Scheme for those volunteers working on projects in the Health Partnership Scheme. DH is exploring how it can help other volunteers.

**Recommendations focused at country level**

Recommendation 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.

**Disagree**

In all the countries in which DFID has a health programme its investments are already based on an assessment of needs and funding gaps, taking into account the activities of
other partners, both domestic and international. The process of developing a business
case for a new investment requires that such an assessment be carried out and the
annual review process provides an opportunity to revisit it. In countries which both
have UK bilateral programmes and are recipients of Gavi and GFATM funds, DFID
staff work to ensure complementarity, with each organisation working to its
comparative advantage and engaging closely to achieve the best possible outcomes.

DFID is also stepping up its efforts to ensure that funding channelled through Gavi and
the Global Fund supports the UK’s objectives at country level. A framework is being
developed to better monitor the effectiveness of global funds in country. As part of this,
DFID’s Global Funds Department will work with country-based health advisers to
receive regular feedback, including on health systems strengthening, which will be used
to inform DFID’s annual reviews of its investments through Gavi and the Global Fund
and the UK’s positions in these organisations’ Boards and Committees.

In future the proposed DFID health systems strengthening framework will help to
provide a stronger basis for monitoring of the UK’s overall impact on health systems at
country level.

Recommendation 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

Partially agree
The IHP+ core team is funded until 2015. DFID will continue to adopt IHP+ principles
and behaviours, and will encourage its international partners to do so. This will include
both advocacy at country level and continuing senior-level participation in the work of
the group of global health agency leaders, whose purpose is to accelerate progress on
and implementation of the agreed principles of the IHP+.

Recommendation 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.
**Partially agree**

The majority of financing for health in most countries already comes from domestic sources, including government revenues and individuals’ own pockets. As countries’ economies grow, they will have an opportunity to invest more in health if they choose to do so. They will also begin to graduate from funding sources such as the Global Fund and Gavi.

Challenges in future health financing include persuading governments that health is a good investment. Better health care is known to be one of the things people value most highly, but not all governments are incentivized to ensure it is provided. It needs to be part of the social contract between a government and its people.

Future financing for health is being discussed widely, with a focus on non-aid sources such as more domestic resource mobilization and attracting more financing from private investors through impact investing and Development Impact Bonds. DFID will work more on all of these areas in future.

DFID continues to actively make the case for investment in health systems and to invest in evidence to strengthen this case, including the work of the 2013 Commission on Investing in Heath. DFID will use the opportunity of developing its new research priorities and the proposed performance framework for health systems strengthening to look again at the evidence and identify remaining gaps.

The most effective agents of change for DFID to work with to raise the priority governments give to health will differ from country to country. A thorough political economy analysis is needed to help identify them. In some countries, working more with Parliamentarians and medical professionals as advocates for greater health expenditure may be effective; in others using agents such as civil society and the media to hold government to account for financing health may be more influential.

**Recommendation 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.

**Agree**

The Government promotes the development of inclusive health systems. Much of DFID’s work is targeted at identifying and tackling inequities in access to health for the poorest and most marginalised, including women and girls, disabled people and ethnic minorities. It is clear that the poorest and most marginalised suffer most: they are not only more exposed to health risks but also less able to take preventive measures and less
likely to have access to services. They are more likely to be ill, less likely to receive care and more likely to die or suffer long term disability.

The UK Government has shown international leadership on family planning, HIV, nutrition, female genital mutilation and early and forced child marriage, all of which require dismantling cultural barriers. The UK’s view is that deep-seated cultural barriers that prevent people from accessing services are best overcome by empowering people in the communities concerned. That is why, for example, DFID is supporting an Africa-led movement to end female genital mutilation and child, early and forced marriage in a generation.

The growing international focus on universal health coverage is helping to attract attention to a range of barriers to access, including cultural barriers. Without tackling these barriers, countries will not be able to achieve UHC.

**Research and evidence**

**Recommendation 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.*

**Partially agree**

DFID has a strong history of supporting health systems research and is seen as a leading funder in the field. The Human Development team in DFID’s Research and Evidence Division is currently developing future research priorities to provide evidence that will support the achievement of the post-2015 development goals. This process will involve a range of activities, including an expert roundtable event and both internal and external consultations, to be held in 2015. The exercise will identify DFID’s future global health research priorities, which will determine how best to continue DFID’s significant investments in health systems research and its component pillars, including human resources for health. The Committee’s recommendations will be taken into account in this process.

**Recommendation 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.

**Agree**
The Government agrees that community health workers can play an important role in health systems but that this role should be carefully defined and evidence-based. DFID is already contributing to expanding the evidence base, including by funding a multi-country study of the cost-effectiveness of community health workers in different settings and by supporting the REACHOUT research programme consortium, which focuses on the role of close to community health workers. DFID will look at additional research needs as part of developing its new research strategy and its approach to human resources for health.

**DFID leadership**

Recommendation 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.

Agree

The UK Government is now increasingly focussed on tackling the underlying causes of poverty by supporting strong and inclusive economic, social and political institutions to establish what the Prime Minister has termed ‘the golden thread’ of development. Basic service delivery is often one of the most significant ways in which citizens come into contact with the state. Visible inequity in access to basic services and/or visible corruption can undermine citizens’ perceptions of the state, with potentially negative effects for state-building and the wider social contract between a government and its people.

Poor governance – such as weak public financial management or procurement processes or the absence of transparency & accountability – can result in corrupt or wasteful practices. Where this results in less money or less efficient use of limited financial resources for service delivery, it leads to slower progress in improving health outcomes.

DFID already supports the strengthening of domestic health financing systems through both bilateral and centrally-managed programmes, including support to WHO, NICE International and the Commission on Investing in Health, which demonstrated the links between better health and higher productivity. DFID health advisers also make an important contribution to governance and financing by participating actively in policy dialogue at country level.

**Recommendation 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.

Agree
The UK has supported the inclusion of a universal health coverage target under an outcome-focused post-2015 health goal. It will continue to do so as discussions progress.

Moving more rapidly towards UHC requires strengthening the health system (including both public and private sectors) to ensure that good quality essential health services are provided and are used by everyone. It requires work on both the supply side to increase provision and the demand side to remove barriers to access, particularly for the poor. The inclusion of UHC as a post-2015 target will ensure that health systems indicators are defined, agreed and monitored.

The Government agrees that long experience with the NHS gives the UK a particular comparative advantage in supporting other countries to progress more rapidly towards UHC.

The NHS has much to offer to other countries and the UK is already sharing its experience in a number of ways. For example, DFID and DH share the expertise of NHS staff through schemes such as the Health Partnership Scheme, which enables NHS clinicians, technicians and other professionals to work with counterparts in developing countries, for mutual benefit. DFID is also investing in NICE International, which enables other countries to learn from the UK’s experience of making hard choices about which services to fund and developing guidelines to deliver health services that offer good quality and value for money. DFID will continue to explore options so that the experience of the NHS can benefit others.