Commentary

Proposal for a T-Shaped Approach to Health System Strengthening

Keizo Takemi*
House of Councillors, Tokyo, Japan

On September 25, United Nations Member States adopted the 2030 Agenda for Sustainable Development. This agenda will be applied to all people throughout the world, “taking into account different national realities, capacities and levels of development and respecting national policies and priorities.” This requires all Member States to hold more ownership over priority setting and program implementation. In the health field, the targets were expanded to include physical and mental health and well-being, and emphasis was given to universal health coverage (UHC) and access to quality care. How can we deliver on these ambitious goals given our limited financial, administrative, and human resources? As the Prince Mahidol Award Conference 2016 theme highlights, evidence-based priority setting for UHC is critical.

First of all, at the national level, political commitment to UHC is essential for delivering on the new Sustainable Development Goals. The health agenda and UHC should be prioritized in national policies and budgets, and UHC should be recognized as an instrument for countries at all levels of social economic development to achieve inclusive and sustainable development. Achieving UHC does not necessarily have to be costly. Japan started its social health insurance program in 1927 when its gross domestic product per capita was 1,869.77 USD (Geary-Khamis dollars), and health care substantially contributed to a reduction of the Gini index during the 1967–1972 period of high economic growth and also contributed to inclusive development.

Setting priorities for UHC requires administrative and management capacities at all levels of government, from national to community levels, under strong leadership. To prioritize health issues, each country needs to strengthen its disease surveillance capacity and information management systems as well as improve its governance to ensure accountable and inclusive decision making.

However, in today’s world, few developing countries have the capacity to formulate and implement UHC policies based on their priorities without external funds and technical assistance, so the global community—donors, development
agencies, and other non-state actors—should support them in setting evidence-based priorities and developing long-term strategies with consideration of epidemic and demographic changes and economic prospects. Only priority setting and strategy development based on the analysis of real circumstances, taking into account the political, economic, and social contexts of each country, will enhance the resilience of national health systems and communities, allowing them to eventually manage their systems without external assistance.

In 2016, Japan will host the Ise-Shima G7 Summit, the first G7 Summit after the adoption of the 2030 Agenda for Sustainable Development. Japan has shown its strong commitment to global health in past G8 summits. The Okinawa G8 Summit in 2000 contributed to the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and the Toyako G8 Summit in 2008 affirmed the importance of health system strengthening (HSS) and the necessity of promoting a good balance between vertical and horizontal approaches.4 Following that summit, the diagonal approach was proposed and the Health Systems Funding Platform was established in 2009 by the GAVI Alliance (now Gavi, the Vaccine Alliance), Global Fund, World Bank, and World Health Organization to harmonize health systems support by restructuring existing funding streams. At the same time, initiatives focused on each building block of health systems were launched in 2006 by the World Health Organization with the publication of “Everybody’s Business.” However, block-specific approaches have faced challenges in keeping momentum and yielding concrete results in strengthening health systems, which has led to increasing attention to broader health system interventions that help advance UHC. The Ebola crisis has further shed light on the relationship between disease control programs and HSS and the importance of strengthening system resilience at the local and community levels.

Against this background, I would like to propose that donors and international organizations adopt a “T-shaped approach” to health system strengthening, with an emphasis on management capacity at the local and community levels, using vertical funding as an entry point to promoting HSS and achieving UHC. Japan’s experience with health system development provides concrete examples about how a T-shaped approach works in practice.

In postwar Japan, tuberculosis (TB) was the leading cause of death, and one-fourth of total medical expenditures was allocated to its treatment and prevention. In 1951, the Tuberculosis Prevention Act promoted health checkups, immunizations, and dissemination of appropriate treatments, and a 1955 survey on the status of population screening of TB infection—strengthening networks among public health centers—found that universal coverage for checkups had been achieved.5 The cost for checkups and most of the medical expenditures for low-income TB patients were covered directly by the government, not by health insurance. In addition, in 1961, a system for registering infected patients was introduced and the national government increased the subsidies it provided to prefectures whose governors ordered patients to be hospitalized in isolation wards.

Japan’s TB program contributed to the expansion of UHC in three ways. First, targeted investments for TB strengthened surveillance and public health systems down to the community level. Second, public subsidies for TB prevention and treatment enabled social health insurance programs to expand their coverage in terms of both population and services.5 Third, the subsidies encouraged local governments to comply with the TB control guidelines and strengthen systems for prevention awareness, vaccination, screening, and health service provision.

Japan’s experience with TB suggests that if the disease burden exceeds the health insurance fiscal space, a disease program covered in a separate budget can contribute to the expansion of coverage of other basic health services by health insurance, and subsidies to local governments can encourage them to implement disease control programs. However, services for specific diseases should be purposefully delivered in a way that strengthens the existing health system and reaches the most vulnerable populations in communities by engaging community organizations and civil society organizations. The funding for disease programs can be raised from external sources; however, it should be on the condition that the country prioritize UHC and primary care in its national policy and budget and mobilize domestic resources for the disease program even incrementally. For that purpose, one approach may be to provide grants for disease programs on the condition that the recipient countries raise domestic resources equivalent to a certain percentage of the grants.

In order to promote the T-shaped approach to health system strengthening, a country’s strategic management capacity needs to be enhanced beyond specific diseases and HSS programs and at all administrative levels. A public–private platform should be created for those who are engaged in disease-specific and HSS programs to set priorities and develop common strategies. Though we can cite many examples of contributions to HSS by people trained by disease programs, we should intentionally promote multistakeholder processes with political wisdom from the outset—with UHC as a common goal. Currently, major global health organizations are discussing new approaches to determining health needs and governments’ abilities and capacities to provide equitable
access to health for all its citizens. I hope that these collaborative efforts will come up with concrete ways to help countries to identify their challenges and define their priorities in achieving UHC in a practical way by implementing disease programs as an entry point to promoting UHC and health system strengthening. This proposal for a T-shaped approach to HSS provides an additional strategy for how context-specific UHC can be accomplished.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflicts of interest were disclosed.

REFERENCES

[1] Ban KM. Transforming our world: the 2030 Agenda for Sustainable Development. September 2015. Available at https://sustainabledevelopment.un.org/post2015/transformingourworld (accessed 5 October 2015)

[2] Maddison A. Historical Statistics of the World Economy: 1–2008 AD. Groningen: University of Groningen; 2010. Available at http://www.ggdc.net/MADDISON/oriindex.htm (accessed 26 October 2015)

[3] Oshio T, Miake N, Ikegami N. Macroeconomic context and challenges for maintaining universal health coverage in Japan. In: Universal health coverage for inclusive and sustainable development: lessons from Japan, Ikegami N, ed. Washington, DC: The World Bank; 2014; 27-40.

[4] Reich MR, Takemi K. G8 and strengthening of health systems: follow-up to the Toyako Summit. Lancet 2009; 373(9662): 508-515.

[5] Shimao T. Contribution of the revision of Tuberculosis Prevention Act to achieving UHC in Japan [in Japanese]. Tokyo: Ministry of Health, Labour and Welfare of Japan; 2013.

[6] The Global Fund to Fight AIDS, Tuberculosis and Malaria. Terms of reference for the Equitable Access Initiative. 2015. Available at http://www.theglobalfund.org/documents/eai/EAI_EquitableAccessInitiative_ToRs_en/ (accessed 26 October 2015)