Strengthening district health systems

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It is increasingly recognized that stronger health systems are needed to deliver health care interventions at the scale necessary to achieve and sustain health-related Millennium Development Goals (MDGs), especially in Africa (*1*, *2*). This is evident in the growing willingness of two of the largest global health initiatives, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Global Alliance for Vaccines and Immunization, to allow increasing shares of their contributions to be used for investments in health systems strengthening. This is welcome news, especially for the peripheral front lines of delivery systems.

How can we strengthen health systems to respond to these new resources? As there are so many needs and entry points, it is tempting to bypass the system with vertical approaches, but the space for such approaches is increasingly crowded as they depend on and compete for the same health workers and management capacities. For this reason, the recent experience of strengthening subnational health systems in the United Republic of Tanzania (*3*) deserves our attention.

A demonstration project was started in 1997 in two large rural districts (the Tanzania Essential Health Interventions Project, TEHIP).[a] The project explored how to use limited resources efficiently in view of forthcoming policies on sector-wide approaches (SWAps) to decentralized district funding. Within five years, these districts had improved the mix and quality of primary care services, increased the coverage and use of these services, and reduced infant and under-five mortality by over 40%. Significantly, this was accomplished by using a donor-provided extrabudgetary increment of about US$ 1 per capita per year and a tool kit of about ten simple tools and strategies aimed at various elements of the health system (*4*). The *stewardship* function was met by relaxing the normal constraints on the use of basket funding, thus permitting district health management teams to invest in strengthening their own practical management and administration skills; *financing* meant having a truly untied sector basket fund under the full control of the decentralized local health authority; and *resources* involved simple computer tools that guided budgeting and resource allocation alignment with priorities, and mapping that revealed infrastructure and human resource priorities. *Delivering services* was ensured by a priority-setting tool that integrated new health informatics (sentinel household surveillance systems) into routine health information systems, thus communicating population burden of disease in terms of interventions; new approaches to management, communications and supervision; community-led rehabilitation and ownership of health facilities; and the freedom to invest in prioritizing and scaling up new interventions such as the Integrated Management of Childhood Illness (*5*) and insecticide-treated bednets.

The TEHIP experience showed, first and foremost, that investing in health systems works: the investment needs to be on multiple, system-wide fronts as determined by needs felt at the decentralized level, and there is no single system intervention to which health gains can be attributed. Initially, the system intervention tool kit was thought to require only tools for burden-of-disease analysis and cost-effectiveness, but the project also responded to more mundane management and administrative issues such as team building, budgeting, mapping, informatics, transport and communications. The second major lesson is that local ownership of the process and control of the resources, with annual plans and priorities decided by the districts themselves, gave a greater incentive for the districts to make their plans work. The third lesson is that system gains are not quick fixes: there is need for a longer time frame and incremental change. Despite initial capital investments on infrastructure, the absorptive capacity for district SWAp financing was very much less than US$ 1 per capita in the first years of the project. If the project had stopped after the usual three years, there would have been no conclusions; the gains accumulated to impressive levels, however, after five years.

It should not be surprising that a multi-pronged approach to improving both technical and allocative efficiency in the health system should reap benefits. It has already been shown that available interventions, if provided at reasonable levels of coverage, could reduce child mortality by over 60% (*6*). The TEHIP results are in line with this view, but questions remain. We know how hard it is to scale up coverage for relatively well-defined technical health interventions (*7*). Will we be able to scale up multiple and much more nebulous system interventions such as those used in TEHIP? The answer probably lies in the appreciation that attempting to do both simultaneously will provide the synergies to obtain the outcomes required by the health MDGs. Having funding to strengthen the system hand-in-hand with support for expanded coverage of essential health interventions worked in the United Republic of Tanzania. The new global health resources with widened scope for system strengthening create an unparalleled opportunity for such advances elsewhere.

A final TEHIP lesson revolves around health systems research. Health systems in low resource settings share many common features but are at the same time contextually unique. Health systems research needs to be seen as an integral function of each national health system and needs to exert more leverage on policies and practice as shown by TEHIP (*8*). Since the health system is emerging as the major constraint to achieving health MDGs (*9*), novel, greater and more coherent support to health systems research is urgently needed. ■

References

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