# District Health Systems – Is this WHO initiative still a viable concept?[[1]](#footnote-1)

In this paper I review the history of District Health Systems (DHS) as it has progressed at the international level between the time WHO advanced this concept in the 1980s up to today. Three stages are highlighted. The first stage looks at the early time when DHS was a part of WHO’s primary health care strategy. The second part explores how the selective PHC counter-revolution undermined the attention given to DHS, especially in light of the World Bank’s approach to health systems development. The third part explores the current state of affairs. The paper ends with a brief discussion of what it might take to keep the DHS vision alive.

### The WHO DHS Initiative

No special attention was given to the district level at the time of Alma-Ata. It was the Technical Discussions held in 1981 by the 34th World Health Assembly which examined the nature of the support needed from district or first referral level to primary health care action at the periphery. District health systems were then strongly promoted by WHO as part of a “renewed effort to implement Primary Health Care and to strengthen the intermediate level in order to support and invigorate this effort” (WHO 1988).

At first glance the emphasis place by WHO on district health systems would seem to be a logical development that extended previous models for a health infrastructure to embrace more fully the importance of community involvement and intersectoral coordination. As outlined by Rex Fendall, a public health specialist with many decades of experience in Africa, DHS represented the third step of a historical process, the first two being dispensaries and the basic health services (Fendall 1986). But Fendall and others knew that matters were far from being this simple. The primary health care movement was in jeopardy. Instead of there being a universal acceptance of an integrated approach to health, as called for the Alma-Ata Declaration, vertical disease control programs persisted, with priority being given to so-called ‘selective’ primary health care (see below).

WHO promoted district health systems based on primary health care in opposition to selective PHC. DHS offered “an excellent practical model for health development” (Smith and Bryant 1988). Its defining characteristics were primary level facilities and community health workers who delivered integrated preventive and curative services to a defined population with the active participation of the community and under the supportive supervision of a district hospital and district health management team. By adding the “essential element of the local hospital”, it was hoped that complementary referral services (notably emergency obstetric and surgical care) and superior resources would be made available to support integrated district-wide care (Segall 2003).

Perhaps the most important event concerning district health systems was the interregional meeting held in Harare, Zimbabwe, in August 1987 (WHO 1987), organized by WHO with the co-sponsorship of USAID, CMC, UNICEF, UNDP, and DANIDA, whose objectives were to review the experiences of participating countries; to identify successful approaches to overcoming common constraints; to formulate concrete proposals and make recommendations for reducing the constraints and promoting the wider application of more effective implementation of district health systems based on primary health care.

The meeting adopted a Declaration in which a district health system was taken to mean “a more or less self-contained segment of the national health system which comprises a well-defined population living within a clearly defined administrative and geographical area, either rural or urban, and **all** institutions and sectors whose activities contribute to improved health” (emphasis added). WHO pushed for DHS for another 8 years or so, as witness the continued flow of papers dedicated to this subject:

* *The challenge of Implementation: District Health Systems for Primary Health Care* (WHO 1988)
* *Towards a healthy district: Organizing and managing district health systems based on primary health care (Tarimo 1991)*
* *Health development structures in District Health Systems* (WHO 1994)
* *District health systems: global and regional review based on experience of various countries* (WHO 1995)
* *The role of civil society in District Health Systems* (WHO 1996).

## The “Counter-Revolution” Sets In (Newell 1988)

Selective PHC was first promoted as “an interim strategy for disease control in developing countries” (Walsh and Warren 1979). In an age of diminishing resources a “rationally conceived, best-data-based selective attacks on the most severe public health problems facing a region” were needed. The identification of those diseases to be attacked required an assessment of their prevalence, morbidity, mortality and feasibility of control (including efficacy and cost). Once diseases were selected for prevention and treatment, the next step was to devise intervention programs of “reasonable cost and practicability”. While they were not in a position to specify what should be included in a selective approach to controlling endemic diseases, the authors proposed a package of care for children up to three years of age and women in the childbearing years. Soon thereafter, UNICEF shifted from being full supporters of PHC to one that focused primarily on growth charts, oral rehydration, breast-feeding, and immunization for children.

While WHO still continued to promote the importance of developing health system infrastructures, the World Bank was seduced by the arguments supporting ‘selectivity’. Its’ seminal 1993 World Development Report on the theme of “Investing in Health” spoke of the need for governments to redirect their spending to “more cost-effective programs that do more to help the poor” and to promote “greater diversity and competition in the financing and delivery of services” (World Bank 1993). Health systems were judged to be spending public money on health interventions of low cost-effectiveness, such as surgery for most cancers, while ignoring highly cost-effective interventions, such as treatment of tuberculosis; to be ignoring the poor, while providing services to the affluent in the form of free or below-cost care in sophisticated public tertiary care hospitals and subsidies to private and public insurance; and to be wasting money by purchasing brand-name pharmaceuticals instead of generic drugs, providing health workers that were poorly deployed and supervised, and providing hospital beds that were not needed.

Governments were called upon to reduce spending on low cost-effective measures in order to be able to finance and implement a package of essential public health interventions and essential clinical services. Management of government services needed to be improved through such measures as decentralization of administrative and budgetary authority and contracting out of services. Governments were pushed to promote diversity and competition, including the private sector providing insurance and clinical services outside the essential package. Health education was emphasized as a means of making the public aware of measures that they could purchase with their own money, which in their search for ‘value for money’ could help improve the decisions of private consumers, providers and insurers.

In the following year, in a 260 page manuscript, the Bank outlined a program for Africa that was more inclusive in its content than any previous document as, in addition to the standard elements of a health system, it covered important subjects related to rural development (World Bank 1994). While the advice provided in this document was much less dogmatic than its 1993 report, prominence was still given to identifying cost-effective packages of services, with district-based care networks, including health centers and first-referral hospitals being responsible for the delivery of these packages. Also called for was improved management of the essential inputs to health care pharmaceuticals, health sector personnel, and health sector infrastructure and equipment.

In a parallel publication, senior Bank economists spelled out what governments needed to do to support this strategy and to make the transition from what existed today to a system based on the delivery of an “essential national package of health services” (Bobadilla et al 1994). Where governments financed and provide health services, they “can use input availability, norm setting, training, and consumer education to affect which services are utilized”. They can facilitate the delivery of the package by financing the inputs needed (drugs, personnel, supplies, equipment) and not finance specialist physicians, sophisticated equipment, and drugs for discretionary services. Most importantly, new investments, both physical and human resources, should be directed at the inputs needed to deliver the national package in order to correct existing imbalances over time. And to the extent feasible, governments can improve resource allocation by redirecting recurrent spending toward lower-level facilities, which provide most of the cost-effective interventions.

The Bank’s strategy abandoned the PHC principle that called for an integrated approach to health services development. The central place given to financing and economic analyses pushed aside any need for communities to have a say in the kind of services they wished the government to provide and how, through their participation, such services could be made more effective and less costly. By confining its health development strategy to health services, the Bank undermined the critical role that the health sector could and should play in determining what cross-sectoral action is needed to improve health.

Following the election of a new Director-General in 1996, WHO soon followed the World Bank’s lead. Dean Jamison, the health economist who served as director of the World Bank’s 1993 report, joined WHO where he was the lead author of the 1999 World Health Report. That report advocated a “new universalism” which recognized governments’ limits but retains “government responsibility for leadership, regulation and finance of health systems” (WHO 1999). Diversity was welcomed, along with “competition in the provision of services, “as long as it was subject to appropriate guidelines”. At the same time the new universalism recognized that if services were to be provided to all then not all services could be provided – “the most cost-effective services should be provided first”.

The 1999 report aimed to demonstrate what strategic changes WHO had made under its new leadership. The *2000* World Health Report was directed to the Member States (WHO 2000). It represented a radical departure from what WHO had previously advocated. Instead of placing priority on those district level functions that were needed to strengthen PHC at community level, financing mechanisms were put forward as the means whereby governments would choose and organize those services determined to be most cost-effective, using methodologies similar to those advocated by the World Bank in 1993. Revealingly, only one reference to district health is made in this report in a paragraph that indicates that it is the central ministry that may need to decide on major capital decisions, such as tertiary hospitals or medical schools, while “regional and district health authorities should be entrusted with the larger number of lower-level purchasing decisions, using guidelines, criteria and procedures promoted by central government”.

What the 2000 World Health Report had done was to relegate primary health care to a “second generation” reform. Its authors had carried out an analysis that was “historically flawed and ideologically biased” (Segall, 2003). Other critics stressed how the reforms being called for “did not consider the unique characteristics of each country. Instead, they tended to adopt standardized models that focused on changes in financing and management, the deregulation of the labor market, decentralization, and the promotion of competition among the different health providers and insurers [thereby] failing to promote essential coordination and synergy among the system’s functions” (PAHO 2011). That these reforms were being driven by neo-liberal ideologies was not lost on many critics as well. Contrary to the hopes of the Banks economists, rather than freeing government funds to meet the priority needs of the poor, the private sector gained ground by providing more health care to the richer population segments while local and intermediary primary health care was allowed to languish (see, for example, Turshen 1999).

Unfortunately, the World Health Report 2000 chose to rank countries according to four key functions (providing services; generating the human and physical resources that make service delivery possible; raising and pooling the resources used to pay for health care; and “most critically”, the function of stewardship – setting and enforcing the rules of the game and providing strategic direction for all the different actors involved), and by doing so, it provoked so much backlash from countries that felt they were unfairly ranked, there was no debate of the critical issues that the report raised – for example, the plight of human health resources, “the most important of the health system’s inputs”. That matters were not going well can be judged by the question being asked: [is] the primary health care approach … still safe in the hands of its parents, the World Health Organization?” (Segall 2003). The People’s Health Movement (PHM) thought it was not: WHO was "paying lip service to the PHC approach," as it was "in practice promoting a completely different route, often detrimental to public health”. WHO's approach, according to the PHM, remained "highly selective and disease focused and driven by donor initiative at the expense of people-centred and holistic approaches (PHM 2003). It’s People’s Charter for Health demanded a “radical transformation of the World Health Organization so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people’s organizations in the World Health Assembly, and ensures independence from corporate interests” (PHM 2000).

## DHS Almost Lost in WHO’s Return to PHC and the WB’s ‘new’ Approach to Health Systems Development

With another change in WHO leadership, the organization used the celebration of '30 years after Alma-Ata' to revisit primary health care. The WHO 2008 report – *Primary Health Care: Now more than ever* – called for a reorientation of health systems, one based on sound scientific evidence and on rational management of uncertainty. At the same time health systems should reflect what people expect of health and health care for themselves, their families and their society. Delicate trade-offs and negotiations with multiple stakeholders were called for; the linear, top-down models of the past were no longer seen applicable.

To achieve the desired reorientation, four types of reforms were indicated as being needed:

* *universal coverage reforms* that ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection;
* *service delivery reforms* that re-organize health services around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world, while producing better outcomes;
* *public policy reforms* that secure healthier communities, by integrating public health actions with primary care, by pursuing healthy public policies across sectors and by strengthening national and transnational public health interventions; and,
* *leadership reforms* that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the other, by the inclusive, participatory, negotiation-based leadership indicated by the complexity of contemporary health systems.

The changes called for rely on the alignment of the different components or building blocks of health systems, i.e. “the health workforce; the health information system; the systems to provide access to medical products, vaccines, and technologies; the financing system; and leadership and governance, and on the way they jointly translate health-sector inputs into overall action” (WHO 2008).

To move towards universal coverage was seen to require a combination of (i) the extension of health-care networks where they are not available; (ii) the shift from reliance on user fees levied on the sick to the solidarity and protection provided by pooling and prepayment; and (iii) the development of mechanisms of social health protection.

To ensure that services deliver appropriate care, networks of primary care teams” were called for. As illustrated below, each team would serve as a “hub of coordination”. It was noted that in many countries, health districts were an “appropriate planning unit for organizing service delivery”.



Transformed into a network, “the relations between the primary-care team and the other institutions and services are no longer based on top-down hierarchy and bottom-up referral, but on cooperation and coordination”. In this arrangement, the primary-care team “becomes the mediator between the community and the other levels of the health systems, helping people navigate the maze of health services and mobilizing the support of other facilities by referring patients or calling on the support of specialized services”.

In a parallel development, the World Bank developed a “new strategic direction” for its work in health in Africa (World Bank 2005). Much had changed in Africa since the publication of their 1993 World Development Report – “not always for the better”. This 300 page report offered to help countries in “setting a strategic agenda for finding the right answers through country-level analytical work and evaluation” while recognizing that it raised “more questions than it answers”.

With its focus on what the World Bank should be doing to help African countries improve the health, nutrition and population (HNP) outcomes among the poor, priority was given to four areas:

* Influencing macroeconomics and fiscal policy as it relates to health, nutrition, and population
* Ensuring that policies and investments outside of the health sector have a positive impact upon health outcomes
* Helping client countries to develop effective service delivery systems
* Ensuring that resources are effectively mobilized and employed in ways that achieve the greatest impact and protect households from impoverishment due to illness

Concerning health systems, the report identified five “challenges” that African ministries of health had to face in improving the effectiveness, efficiency, and coverage of health, nutrition, and population interventions:

* Overcoming workforce-related problems
* Getting the institutional and organizational framework right
* Making pharmaceuticals accessible and affordable
* Strengthening the private sector
* Increasing household and community demand for effective services

Health workforce constraints were identified as the “single greatest challenge to improving service delivery in Sub-Saharan Africa today”. Concerning the institutional framework, new relationships between the public and private sector were seen to be emerging. “Client countries [were] beginning to shift away from the direct provision of services toward a stewardship role”. Combined with decentralization and calls for greater multisectoral action, this shift was altering how ministries of health functioned. Increasingly, client countries were seeking the Bank’s support in “making hospitals autonomous, delinking medical staff from the civil service, and engaging in contracts and grant agreements with districts and with private health care providers”.

In 2007 the World Bank set forth its objectives for the coming decade and the strategies to achieve them (World Bank 2007). The new strategy announced an important shift away from focusing exclusively on outcome indicators (e.g., MDGs) towards “results” that encompass outcomes, outputs, and system performance. This shift was in “response to the complexity, and long-term nature involved in making sustainable improvements in HNP”. Strengthening health systems “remains central” to the 2007 strategy, but no longer is it formulated as an objective. Instead, it is viewed “as the primary means to achieve the objective of improving the health conditions of people in client countries, particularly the poor and vulnerable” (Fair 2008).

While the language of both the WHO and WB documents is not easily comprehended (to this reader at least), it seems clear that the two organizations are emphasizing different aspects of what is needed to strengthen health systems. While the DHS strategy is not totally absent in the current approaches being advocated by both organizations, in the context of the Bank’s heavy reliance on privatization, it is difficult to imagine how this could be otherwise. As far as WHO is concerned, it has moved from what I thought at the time to be an overly simplistic statement of what was needed (the background document to Alma-Ata) to a set of proposals that are so complex as to nearly defy any country to act on them or to understand them for that matter.

Be that as it may, the leadership position of both WHO and the World Bank may be threatened by the G8 being asked to take the lead in the strengthening of health systems, as it “can think and act outside the existing global health bureaucracies and stakeholders” (Reich and Takemi 2009)! Whether this is to be taken seriously or not is not clear. In any case, whoever takes the lead must be ready to hold the fort for decades to come and not, in the process, become equally bureaucratic in the process.

## Is there a future for district health systems?

The nine-point health systems development agenda for low-income countries put forward by Global Health Watch (GHW) in 2006 includes district health systems. While noting that the rationale of the DHS model had been promoted by WHO and others, implementation had been “undermined by the effects of structural adjustment programmes; the persistence of vertical programmes and top-down management cultures; market-based policies; and a reluctance to invest in district-level health management structures with authority status and skills” (GHW 2008). The other 8 agenda points put forward by the PHM are: comprehensive human resource plans; adequate, sustainable and reliable public financing for the health system; harmonized, sector-wide coordination and planning; unhindered access to essential health care; effective health-sector management; vertical and horizontal alignment; public accountability and community involvement; and a private sector harnessed to serve the public good.

Although easier to follow than either the WHO or WB proposals, the PHM agenda for action is a highly ambitious one. I would have preferred that the DHS be highlighted as the logical level at which the other actions called for are developed in a linked and timely manner. Dr Mahler outlined an approach at the Harare meeting in 1988 that still seems to be a logical way to move ahead. He envisaged using the “approach of learning-by-doing”, through the systematic and practical application of health systems research in districts” (WHO 1987). This proposal was incorporated in a Framework for Action which outlined five “critical considerations”: experimentation and learning; sustainability; replication and expansion; systems and people development; and system-wide and systems-based change. No blueprint was given; instead, a logical process was outlined which provided “plenty of room for revising, adapting and refining the plans” as implementation progressed (WHO 1988).

District health systems should be recognized as the most desirable form of entry-point for health systems development. The out-dated disease entry points (which are still touted by verticalists) must be recognized as having failed. At best they have yielded short-term and geographically-limited gains. No systems have emerged from vertical campaigns, even from those that were carried out over decades. Even where limited success was achieved, vested interests prevented specialized programs from being converted into comprehensive delivery systems. These vested interests, combined with those of specialized public sector (e.g. hospitals) and the private sector, have hindered serious attention being given to DHS. Let a thousand DHS’s bloom should be our motto for the future.

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1. By Socrates Litsios for Conference at the U. of Basel, 12 to 14 September 2011 – The History of Health Care in Africa: Actors, Experiences, and Perspectives in the 20th Century. [↑](#footnote-ref-1)