

15by2015: strengthening primary health care in developing countries

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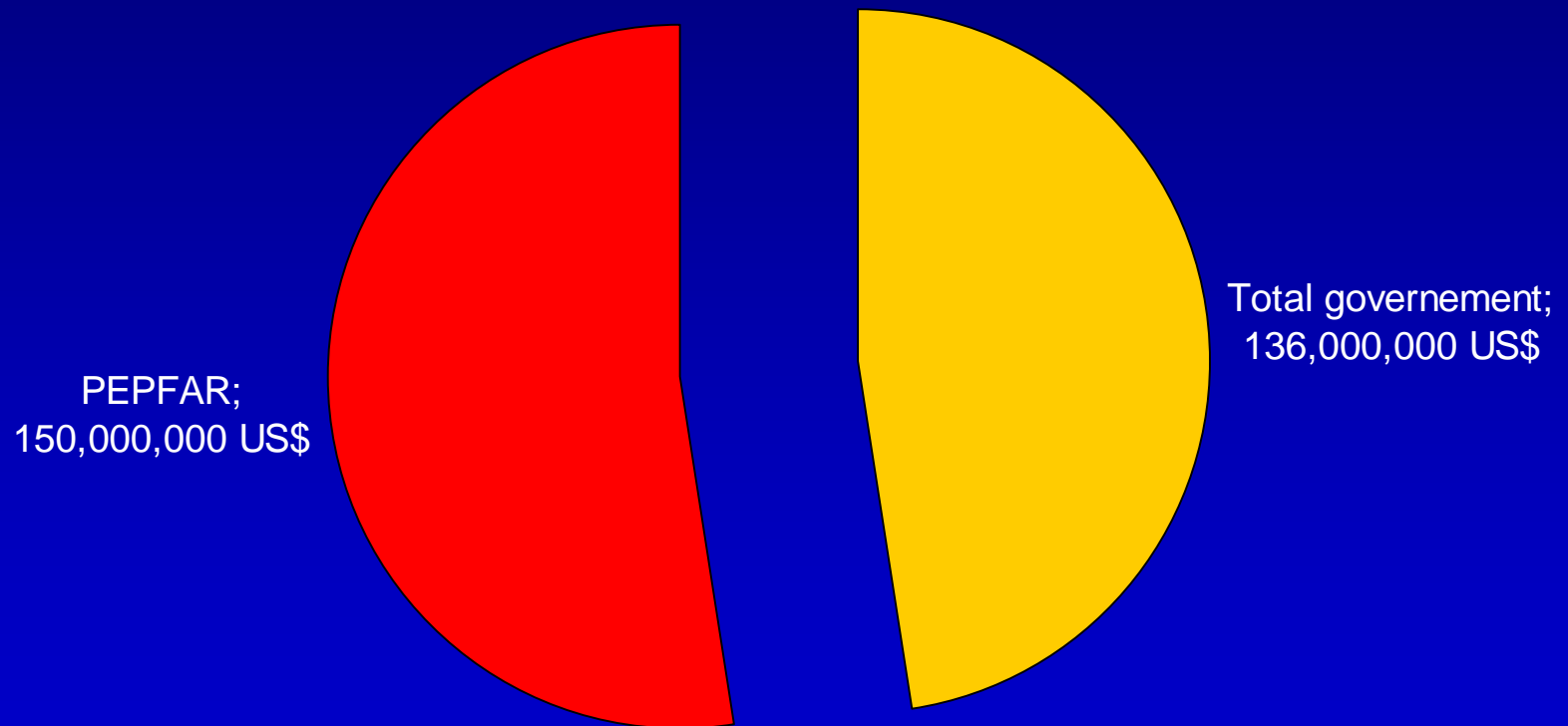
Unprecedented donations and investments to improve healthcare in developing countries

From \$ 6.4 billion to \$ 8.1 billion (1997-2002):

- A positive development
- Allocated towards narrow, disease-specific projects (vertical programming)
- Limited allocations towards broad-based improvements in population health, prevention, primary care services, health workforce development (horizontal programming)

Zambia

- HIV prevalence rate: 16,5%



Selective vs. Comprehensive Health Care

- 1978: Alma Ata Declaration (WHO): comprehensive primary health care: improving health requires, in addition to access to health care, changes in economic, social and political structures. Health and health care are basic human rights that require community participation (horizontal programming).
- Selective health care: targets specific diseases (vertical programming). Alma Ata concepts are unattainable. A more selective approach, addressing the greatest disease burden in the community, will have a better chance of improving health in less developed countries.

The AIDS-epidemic of the late 1970's and the early 1980's generated a strong impetus to develop vertical programs and this selective strategy has been favourably received by international agencies such as World Bank, Unicef, academic institutions and research centres, bilateral aid-agencies and private institutions

Effectiveness and efficiency of selective approaches

- Despite a ten-fold increase in external financing for tuberculosis control in low-income-countries, only 27% of patients have access to the package set out in DOTS.
- By mid 2004, less than 5% of AIDS patients in sub-saharan Africa were under treatment (comparison: over 50% in the Americas)

	ARI	AIDS
Disease burden	26%	31%
Donor funds	2,5%	46%

Vertical programs

- Create duplication
- Lead to inefficient facility utilisation
- May lead to gaps in patients with multiple co-morbidities
- Undermine government capacity

Examples from daily practice

- Consequences of selective approaches for quality of care
- Consequences in terms of access to care

Vertical programmes and internal brain drain

- Well-financed, vertical programs
- Example: Ethiopia

“The implementation of the Global Fund proposal required human resources: local medical staff was hired on consultancy contracts at triple the salary available in the public sector. This has “diverted” skilled local health personnel from the poor local (primary) health care system.”

*“For treatment of chronic diseases there is a need to shift successfully to community-based and patient-centred paradigms of care.”**



“The primary health care, with the family physicians and primary care nurses as the clinical disciplines, contributes to this shift.”

(*Source: The World Health Report 2006)

Comprehensive Primary Health Care contributes to a high quality, cost effective health system

1. Greater access to health care services, based on health needs
2. Better overall quality of care
3. Greater focus on prevention
4. Stronger emphasis on early diagnosis and management of health problems
5. Reduction of unnecessary and potentially harmful interventions

(Source: Starfield B, et al. Contribution of Primary Care to health systems and health. Millbank Quaterly 2005;83:457-502)

Effectiveness of primary care

- Bolivia: community-based primary health care services in socially deprived areas lower the mortality of children under age five
- In India infant mortality rates are lower in states where villages have a primary health care centre
- Primary health care reduces inequality in health care provision

Code of best practice for disease control programmes to avoid damaging health care services in developing countries¹.

*“Disease control activities should be integrated in health centers, which offer patient-centered care and should be designed and operated to strengthen health systems”.*²

Source: ¹ Unger JP, De Paepe P, Green A. A code of best practice for disease control programmes to avoid damaging health care services in developing countries. Int J Health Plann Manage 2003;18:S27-S39

² Meads G, Wild A, Griffiths F, Iwami M, Moore P. The management of new primary care organisations: an international perspective. Health Serv Manage Res 2006;19:166-73

15 by 2015

“The World Organisation of Family Doctors, (WONCA) in collaboration with Global Health through Education and Training and Service (GHETS), The Network: Towards Unity for Health, (The Network: TUFH) and the European Forum for Primary Care (EFPC) call upon funding organisations such as the Global Fund, the World Bank, the Bill and Melinda Gates Foundation, and the World Health Organisation, to assign to primary health care a pivotal role in the provision of their activities and to support its development in a systematic way. We propose that by 2015, 15% of the budgets of vertical disease oriented programmes like HIV/AIDS, Tuberculosis and Malaria, be invested in strengthening local primary health care systems and that this percentage would increase over time. Such an investment would improve developing nations’ capacity to address the vast majority of health problems through a generic, well structured comprehensive primary care system.”

Strengthening primary care:

addressing the disparity between vertical and horizontal investment

Recently we have seen an unprecedented increase of financial support to improve health care in developing countries estimated at 26% between 1997 and 2002, from \$6.4 billion to \$8.1 billion.¹ While the magnitude of such an investment is a positive development, the vast majority of aid has been allocated towards disease-specific projects (termed 'vertical programming') rather than towards more broad-based improvements

method is based on a short-term outlook that solves a given health problem (HIV/AIDS) through the application of specific measures. Comprehensive primary health care is carried out through a long-term process that seeks to tackle the overall health problems through the creation of an accessible permanent institutional infrastructure for 'general health services'.

The AIDS epidemic of the late 1970s and early 1980s generated a strong impetus to develop vertical programmes. This strategy



programme requires its own bureaucracy, leads to inefficient facility utilisation by recipients, and may lead to gaps in care especially in patients with multiple comorbidities. Moreover, vertical programmes that are funded externally undermine government capacity by reducing the responsibility of the state to improve health care through its own services.

Well-financed vertical programmes funded by international donors have helped to fill the health care gap

Funding for primary health care in developing countries

Money from disease specific projects could be used to strengthen primary care

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The World Health Organization's World Health Report 2007 deals with access to primary health care as an essential prerequisite for health.¹ It acknowledges the importance of the Alma-Ata declaration of 1978, which called for integrated primary health care as a way to deal with major health problems in communities and for access to care as part of a comprehensive national health system. Yet the mission of Alma-Ata—to provide accessible, affordable, and sustainable primary health care for all—has been implemented only partially in developing countries.² We have therefore instigated the "15by2015" campaign (www.15by2015.org), which proposes a funding mechanism for strengthening primary health care in developing countries.

In the accompanying analysis article, Gillam notes that most developing countries have failed to provide even basic primary healthcare packages. Weaknesses in primary healthcare services often result from a variety of forces, including economic crises and market reforms, which limit the range and coverage of services and thus their effect on health.³⁻⁴ On the positive side, between 1997 and 2002, financial support to improve health care in developing countries increased by about 26%, from \$6.4bn (£3.3m; €4.4m) to \$8.1bn.⁵ However, most aid was allocated to disease specific projects (termed "vertical programming") rather than to broad based investments in health infrastructure, human resources, and community oriented primary healthcare services ("horizontal programming").⁶

An example of vertical programming is the enormous donor response to the HIV epidemic. In 2006, although Zambia's entire Ministry of Health budget was only \$136m, the President's Emergency Plan for AIDS Relief

provided the country with an HIV targeted budget of \$150m. This unbalanced distribution of health funding occurs across sub-Saharan Africa. Thus, although HIV positive patients receive free care, others with more routine diseases receive poor care and still have to pay. Salaries of healthcare providers working for donor funded vertical programmes are often more than double those of equally trained government workers in the fragile public health sector. This lures government workers to the higher paying vertical programmes and creates an internal "brain drain." But it is the underfunded primary care clinics and health centres that care for all diseases, including common illnesses such as diarrhoea, malnutrition, and respiratory tract infections, which take many more lives than HIV, tuberculosis, and malaria.

A new global strategy is needed to reinforce community focused primary health care in developing countries. This will require cooperation between ministries, universities, non-governmental organisations, and donors working on health to overcome severe resource constraints, including insufficient numbers of doctors, pharmacists, and other health personnel. Four international organisations—the World Organization of Family Doctors (www.globalfamilydoctor.com); Global Health through Education, Training and Service (www.ghets.org); the Network: Towards Unity for Health (www.thenetworktufh.org); and the European Forum for Primary Care (www.euprimarycare.org)—have therefore set up the 15by2015 campaign to foster a better balance between vertical and horizontal aid. This campaign calls for major international donors to assign 15% of their vertical budgets by 2015 to strengthening horizontal primary healthcare systems so that all diseases can



World Health
Organization



Commission on
Social Determinants of Health

Closing the gap in a generation

Health equity through action on
the social determinants of health



The World Health Report 2008

Primary Health Care

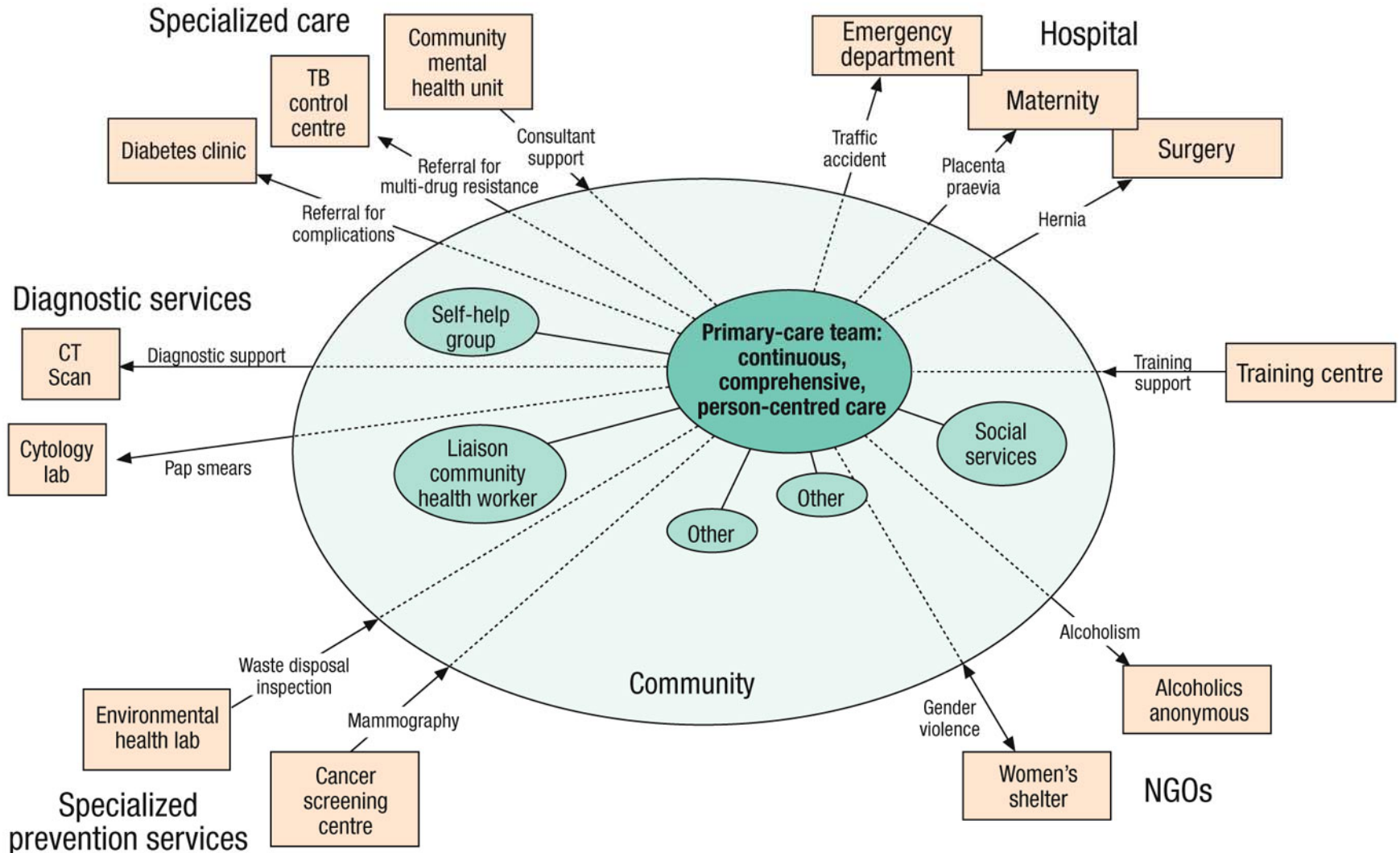


Now More Than Ever



World Health
Organization

Figure 3.5 Primary care as a hub of coordination: networking within the community served and with outside partners^{173,174}



From Alma-Ata to Almaty: a new start for primary health care

On Oct 14, *Now more than ever*, the World Health Report for 2008, was launched at Almaty, a city formerly called Alma-Ata and well known for the 1978 WHO declaration on primary health care.¹ Although many countries tried to put primary care into practice, the declaration's goal of Health for All was not achieved. Will all countries now establish strong and efficient primary care as an integral component of their health systems? Is 2008 different from 1978?

The multiple interacting health problems that are intractable cannot be dealt with without a person-focused population-oriented approach. Vertically oriented and externally funded services interfere with the responsibility of the state to improve its own health services.⁵

The need for integration of health services by primary health care was emphasised by a workshop in May, 2008, in Geneva.⁶ The 15by2015 campaign (launched in March,

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Sign the petition of the “15 by 2015” campaign

We call upon all donor organizations to allocate 15% of their budgets of vertical disease-oriented programs towards strengthening horizontal primary health care systems by 2015

www.15by2015.org

Presently we have almost 1500 signatures
from more than 100 countries

**It's time for change:
YES, WE CAN !**



Thank you!

