[1] INTRODUCTION:

Health centers from around the nation are participating in various types of international work abroad. Although each health center’s motivations to work overseas are varied and unique, there is a growing consensus among health centers of the benefits of working internationally. Such work can be of deep and lasting value to not only the people in the countries abroad but also to the health center staff on the ground and the patients health centers care for. International work can provide individuals with personal inspiration and perspective, which can add to their professional development and growth, thus benefiting the health center when they return.

This toolkit is designed to help strengthen the capacity of the health centers in the U.S. to assist with international development and humanitarian assistance, and to help provide a guide for those interested in working abroad. The toolkit provides anecdotal guidance as well as resources to help health center staff and health center organizations develop their own unique niche in the international world. For those health center staff or health center organizations who are already working abroad this toolkit will provide you with resources that you may not have come across as well as examples of what your peers are doing in the field. The toolkit is meant to be an evolving guide that will be continually enhanced and updated.

We hope this guide will prove useful as you embark on a new chapter of international relations. We welcome any feedback, comments, or suggestions. Please e-mail me at sgitomer@nachc.com.

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Articles Sited in the Toolkit:

7.1 DRAFT: The Surgeon General’s Call to Action on Global Health 2006
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7.2 Going Global: Considerations for Introducing Global Health Into Family Medicine Training Programs (Labeled in Reading as: “Introducing Global health into CHC Residency Training Programs)
Jessica Evert, MD; Andrew Bazemore, MD, MPH, Allen Hixon, MD; Kelley Withy, MD, PhD

7.3 The Shoulder to Shoulder Model – Channeling Medical Volunteerism Toward Sustainable
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7.4 The WHO’s World Health Report 2008: Primary Care – Now More than Ever

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Global Health Policy Readings

The Henry J. Kaiser Family Foundation, Executive Summary: April 2009

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Lindsay Morgan, Policy Analyst Center for Global Development: June 2009

Strengthening International Partnerships in Global Health

7.8 Commentary: Public – Private “Partnerships” in Health – a Global Call to Action
Sania Nashtar; Corresponding Author for Health Research Policy and Systems: July 2004

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Dr. Alan Goldsmith, President; Jewish Renaissance Foundation and Jewish Renaissance Medical Center
Understanding The Role of CHCs in Global Health

[2] BACKGROUND AND CONTEXT:

Health centers are pillars of hope, safety, and accessibility in providing high quality, and cost-effective medical care that is comprehensive, community centered, affordable, and culturally and linguistically competent. Unlike other “mainstream” providers, health centers’ broad definition of health seeks to tackle the social, environmental, and economic causes of poor health and disparities. Given the international pervasiveness of health care disparities, the health center model is transferable to any health care system.

The communities that U.S. health centers serve continue to become more diverse, with many serving recent immigrants, migrant farmworkers, and new subsets of minority populations. Health centers note that the populations they are serving abroad are similar to their patients locally. Although resources in developing countries are considerably less than those in the U.S., the challenges created by low literacy, poor transportation, and limited financial resources are similar. Thus, domestic care among multicultural and underserved patients complements health centers’ innovative programs abroad. Moreover, some health centers have established roots abroad in the exact areas where many of their patients have immigrated from. As a result, health center staff has learned more about their patients’ cultures and new approaches to better care.

The purpose of this section is to give you a background not only on global health and the role of primary care within global health, but also to explain the role and success of the community health center model in providing primary care abroad.

Included in this section:

- **2.1** America’s Health Center Fact Sheet: Health Center 101
- **2.2** The Fundamentals of Community Health Centers
  Jessamy Taylor, Research Associate; George Washington University’s National Health Policy Forum Background Paper: August 2004
- **2.3** What is Global Health and Why Does it Matter?
- **2.4** The Role of Primary Care Within Global Health: A Summary of the 2008 World Health Report “Primary Health Care: Now More than Ever” (Full Report in Appendix)
- **2.5** Community Health Centers Developed in Countries With National Health Insurance
America’s Health Center Fact Sheet: Health Centers 101

WHAT ARE HEALTH CENTERS?

Community, Migrant, Homeless, and Public Housing Health Centers are non-profit, community-directed health care providers serving low income and medically underserved communities. For over 40 years, the national network of health centers has provided high-quality, affordable primary and preventive care, as well as dental, mental health and substance abuse, and pharmacy services. Also known as Federally-Qualified Health Centers (FQHCs), they are located in areas where care is needed but scarce, and improve access to care for millions of Americans regardless of their insurance status or ability to pay. Their costs of care rank among the lowest, and they reduce the need for more expensive hospital-based and specialty care, saving billions of dollars for taxpayers. Currently, around 1,200 health centers deliver care through over 7,000 service delivery sites in every state and territory.

WHO DO HEALTH CENTERS SERVE?

Health centers serve as the medical and health care home for over 18 million people nationally – a number that is quickly growing. Health center patients are among the nation’s most vulnerable populations – people who even if insured would nonetheless remain isolated from traditional forms of medical care because of where they live, who they are, the language they speak, and their higher levels of complex health care needs. As a result, patients are disproportionately low income, uninsured or publicly insured, and minority.

Nearly all patients are low income, with 71% of health center patients having family incomes at or below poverty (Figure 1). Patients also tend to be members of racial and ethnic minority groups, as shown in Figure 2. At the same time, 39% of health center patients are uninsured and another 35% depend on Medicaid (Figure 3). Additionally, about half of health center patients reside in rural areas, while the other half tend to live in economically depressed inner city communities.
HOW DO HEALTH CENTERS OVERCOME BARRIERS TO CARE?

Health centers remove common barriers to care by serving communities that otherwise confront financial, geographic, language, cultural and other barriers, making them different from most private, office-based physicians. They

- **are located in high-need areas** identified by the federal government as having elevated poverty, higher than average infant mortality, and where few physicians practice;
- **are open to all residents**, regardless of insurance status, and provide free or reduced cost care based on ability to pay;
- **offer services that help their patients access health care**, such as transportation, translation, case management, health education, and home visitation; and
- **tailor their services** to fit the special needs and priorities of their communities, and provide services in a linguistically and culturally appropriate setting. Nearly a third of all patients are best served in languages other than English, and nearly all patients report their clinician speaks the same language they do.

For many patients, the health center may be the only source of health care services available. In fact, the number of uninsured patients at health centers is rapidly growing – from 3.9 million in 1998 to 7.2 million today.

HOW DO HEALTH CENTERS MAKE A DIFFERENCE?

Key to health centers’ accomplishments is **patient involvement in service delivery**. Governing boards – the majority of which must be patients according to grant requirements – manage health center operations. Board members serve as community representatives and make decisions on services provided. Active patient management of health centers assures responsiveness to local needs, and helps guarantee that health centers improve the quality of life for millions of patients in the following ways.

- **Improve Access to Primary and Preventive Care**. Health centers provide preventive services to vulnerable populations that would otherwise not have access to certain services, such as immunizations, health education, mammograms, pap smears, and other screenings. Low income, uninsured health center patients are much **more likely to have a usual source of care** than the uninsured nationally. Moreover, uninsured people living within close proximity to a health center are **less likely to have an unmet medical need**, **less likely to visit the emergency room or have a hospital stay**, and **more likely to have had a general medical visit** compared to other uninsured.
Cost-Effective Care. Care received at health centers is ranked among the most cost-effective. Several studies have found that health centers save the Medicaid program around 30% in annual spending for health center Medicaid beneficiaries. Furthermore, health centers generate savings for the entire health care system of up $17.6 billion a year. These savings are the result of less reliance on costly specialty, inpatient, and emergency room care. Furthermore, if avoidable visits to emergency rooms were redirected to health centers, over $18 billion in annual health care costs could be saved nationally.

High Quality of Care. Studies have found that the quality of care provided at health centers is equal to or greater than the quality of care provided elsewhere. Moreover, 99% of surveyed patients report that they were satisfied with the care they receive at health centers.

Reduction of Health Disparities. Disparities in health status do not exist among health center patients, even after controlling for socio-demographic factors. The absence of such disparities at health centers may be related to their culturally sensitive practices and community involvement – features that other primary care settings often lack. Moreover, as more of a state’s low income population is served by health centers, racial and ethnic health disparities in key areas are reduced across the state.

Effective Management of Chronic Illness. Health centers meet or exceed nationally accepted practice standards for treatment of chronic conditions. In fact, the Institute of Medicine and the Government Accountability Office have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer, and HIV. Health centers’ efforts have led to improved health outcomes for their patients, as well as lowered the cost of treating patients with chronic illness.

Improve Birth Outcomes. Health centers also improve access to timely prenatal care. Communities served by health centers have infant mortality rates at least 10% lower than comparable communities not served by health centers. Women of low socioeconomic status seeking care at health centers experience lower rates of low birth weight compared to all such mothers. This trend holds for each racial/ethnic group.

Create Jobs and Stimulate Economic Growth. In addition to health care savings, health centers also bring much needed economic benefits to the low income communities they serve. Their overall economic impact reaches $12.6 billion annually, while also producing 143,000 jobs some of the country’s most economically deprived neighborhoods.

WHY IS INVESTING IN HEALTH CENTERS IMPORTANT?
Expanding and strengthening the Health Centers Program would further reduce health disparities, increase access to high quality and regular care, and boost more local economies. As a result, fewer Americans would rely on costly sources of care, such as the emergency room, thereby saving tax payers significantly and making the overall health care system more efficient. Health centers are therefore good.
The Fundamentals of Community Health Centers
Jessamy Taylor, Research Associate

OVERVIEW — This background paper examines the dominant model of federal grant funding for primary care in the health care safety net: the community health center. It describes the history of the health center program and highlights key policy issues influencing health centers, such as Medicaid payment policies and medically underserved area designations. The paper also examines the recent presidential initiative to expand health centers, including a review of the process used to identify new grantees, an assessment of remaining gaps in capacity, an exploration of continuing challenges, and a discussion of unresolved policy questions.
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About 45 million Americans were uninsured at some point in 2003 and millions more lacked access to care, even if they had public or private health insurance. For the millions without health insurance, getting care means seeking out providers who are either personally committed or legally required to provide services regardless of a patient’s ability to pay. Those with only catastrophic coverage or with Medicaid coverage sometimes find it challenging to identify a provider who will accept their insurance.

The health care professionals who are willing to provide care to the uninsured and underserved form a loosely knit, frayed, and often torn group that is called the health care safety net. It consists of a mix of people and institutions that includes hospital emergency departments, public hospitals, community health centers, free clinics, and private physicians’ offices, among others. Its financing is equally varied and reflects a range of funding sources, such as federal, state, and local expenditures through Medicaid, including the disproportionate share hospital (DSH) program; federal community health center grants; and philanthropic contributions. Although they represent only one component of the health care safety net, health centers are often seen as a pivotal player in this complex web of providers and financing mechanisms.

WHAT IS A COMMUNITY HEALTH CENTER?

The history of federal involvement with today’s community health centers is integrally tied to the Johnson administration’s War on Poverty and the civil rights movement. Initially named neighborhood health centers, these clinics were created in 1965 as part of the Office of Economic Opportunity (OEO) to provide health and social services access points in poor and medically underserved communities and to promote community empowerment. Consistent with the community empowerment philosophy, federal funds for neighborhood health centers flowed directly to nonprofit, community-level organizations, bypassing state governments. The original centers were designed and administered with significant community involvement to ensure they remained responsive to community needs. Funding was approved in 1965 for the first two neighborhood health center demonstration projects, which opened in a public housing project in Boston in 1965 and in Mound Bayou, Mississippi, in 1967. Although the Medicaid and Medicare programs were created around the same time, these new health insurance programs were not integrated with the neighborhood health centers until at least a decade later.¹
In the early 1970s, prior to the dissolution of OEO, the health centers program was moved to the Department of Health, Education, and Welfare (HEW). At this stage, a precursor migrant health program that had been established by the Kennedy administration became part of the neighborhood health centers program. HEW has since become the U.S. Department of Health and Human Services (DHHS). Within DHHS, the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) currently administers the program. In 1975, Congress authorized neighborhood health centers as “community and migrant health centers”, subsequent authorizations added primary health care programs for residents of public housing and the homeless. The Health Centers Consolidation Act of 1996 combined these separate authorities (community, migrant, homeless, and public housing) under §330 of the Public Health Service Act (PHSA) to create the consolidated health centers program. Health center grantees are often called 330 grantees because of this statutory authorization. Most recently, the Health Care Safety Net Amendments of 2002 reauthorized the consolidated health centers program through fiscal year (FY) 2006.

**Federal Grant Requirements**

Although the legislative authority for the health center program has evolved somewhat over the last 30 years, in the most fundamental ways the program remains true to its founding philosophy. To receive §330 grant funds, a clinic must meet certain statutory requirements. It must:

- Be located in a federally designated medically underserved area (MUA) or serve a federally designated medically underserved population (MUP).
- Have nonprofit, public, or tax exempt status.
- Provide comprehensive primary health care services, referrals, and other services needed to facilitate access to care, such as case management, translation, and transportation.
- Have a governing board, the majority of whose members are patients of the health center.
- Provide services to all in the service area regardless of ability to pay and offer a sliding fee schedule that adjusts according to family income. The requirement that a majority of board members be health center patients makes these clinics unique among safety net providers and is designed to ensure that the centers remain responsive to community needs. It generally prevents health centers from being part of a larger enterprise, such as a hospital, local government, or religious order. Health centers that exclusively serve migrants or homeless patients do not have to meet the majority consumer board requirement, nor do health centers in frontier areas.

Although the health centers’ statutory consolidation created a single legislative authority for health center grants, the 330 grant program is...
subdivided into separate grant competitions for community, migrant, public housing, and homeless health centers, thereby allowing communities to tailor applications to their particular needs. HRSA has also funded some school-based health centers, even though the agency does not have an explicit authority to fund school-based programs.

The 2002 health center reauthorization required that grants be awarded for FY 2002 and beyond in such a way that maintains the proportion of the total appropriation awarded to migrant, homeless, and public housing applicants as in FY 2001. In general, about 80 percent of funding is awarded to community health centers with the remaining 20 percent divided across migrant, public housing, homeless, and school-based centers.

The 330 grant program has grown significantly, both in number of grantees and funding level, since health centers were first funded in 1965. In 2003, 890 federally funded health center grantees provided care at 3,600 comprehensive health care delivery sites to over 12.4 million patients. For fiscal years 2003 and 2004, federal grant funding for the consolidated health centers program totaled $1.47 billion and $1.57 billion, respectively. It is important to note, however, that health center budgets consist of a variety of funding sources; federal grant funds constitute only one-quarter of overall health center revenues.

Because the intent of health center grants is to fund direct services, HRSA has always limited the amount of grant dollars that could be used for capital-related purposes. From 1978 to 1996, the health center statute allowed health centers to use grant funds for construction, renovation, and acquisition and to purchase equipment. In 1996, however, Congress revised the statute to prohibit the use of grant funds for construction; the statute still allows the use of grant funds for acquiring and leasing buildings, minor renovation, and equipment purchase or leasing.

HRSA currently allows grantees to use up to $150,000 from their first year’s budget on activities associated with equipment or capital alteration. HRSA also offers a loan guarantee program to grantees and funds a nonprofit organization to assist health centers in accessing capital resources. Although no published data exists to quantify the impact of these statutory and administrative limitations, anecdotal accounts suggest that health centers struggle to access capital funding to address aging or outgrown structures and equipment, as well as the costs of moving to electronic health records, among other things.

**Federal Payment Policy**

Though 330 grant funding is important to health centers, federal reimbursement policy under the Medicaid program is perhaps even more critical to centers’ continued viability. In 1989, Congress created the Federally Qualified Health Center (FQHC) program in response to concerns that health centers were using 330 grant funds, intended to support care for
the uninsured, to subsidize low Medicaid payment rates. The FQHC program established a preferential payment policy for health centers by requiring “cost-based” reimbursement for both Medicaid and Medicare. The methodology that resulted paid health centers on the basis of their actual costs for providing care, not by a rate negotiated with the state Medicaid agency or set by Medicare. Congress has subsequently made changes to this cost-based reimbursement policy, which will be discussed later in this paper.

Eligibility for FQHC designation is limited to three types of primary care clinics: (a) those that receive a grant under §330 of the PHSA (commonly called “health centers”), (b) those determined by the Secretary of Health and Human Services to meet all the requirements for receiving such a grant but do not actually receive grant funding (commonly called “look-alikes”), or (c) those outpatient facilities that are operated by a tribe or tribal organization or by an urban Indian organization.

The Centers for Medicare and Medicaid Services (CMS) is responsible for administering FQHC payment policy. However, HRSA determines FQHC eligibility for 330-funded health centers and look-alikes, and the Indian Health Service determines eligibility for tribal and urban Indian programs. About 80 percent of FQHCs are 330-funded health centers, 10 percent are look-alikes, and 10 percent are tribal or urban Indian facilities. As of August 2004, over 900 health center grantees, 93 look-alikes, 79 outpatient tribal health organizations, and 19 urban Indian health facilities were qualified FQHCs.

The Rural Health Clinic (RHC) is another type of clinic that receives cost-based reimbursement from Medicaid and Medicare but is not an FQHC. This designation was created by Congress in 1977 to facilitate payment to clinics staffed substantially by nurse practitioners and physicians assistants and located in federally designated rural areas with limited access to primary care services. RHCs differ from FQHCs in significant ways. For example, RHCs can be for-profit; can be part of a Medicare participating hospital, skilled nursing facility, or home health agency; and are not mandated to provide care to everyone regardless of their ability to pay. RHCs do serve some Medicaid and uninsured patients, but the majority of their patients are covered by Medicare or private insurance. The rules governing cost-based reimbursement for RHCs also differ from those governing FQHCs, and a clinic cannot be dually designated as both an RHC and FQHC.

The federal terminology (see sidebar) for describing primary care sites can be confusing and may not be operative at the community level. Community leaders

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**Terminology**

**Community Health Center or Health Center:** An outpatient clinic that receives grant funds from the federal government through §330 of the Public Health Service Act (PHSA).

**Look-alike:** An outpatient clinic that meets all requirements to receive §330 grant funds but does not actually receive a grant.

**Rural Health Clinic:** An outpatient clinic that may be for profit, is located in a rural HPSA or MUA, and uses nurse practitioners and physician assistants to provide the majority of care.

**Tribal or Urban Indian FQHC:** An outpatient clinic or program operated by a tribe or tribal organization or by an urban Indian organization.
may refer to their hospital-based outpatient facility—which does not receive 330 funds and is not designated as either an FQHC or RHC—as a “health center.” For the purposes of this paper, however, the term health center is reserved for clinics that receive 330 grant funds. References to FQHCs and other types of clinics will be appropriately qualified.

WHERE ARE HEALTH CENTERS LOCATED?

Health centers are located in all 50 states, the District of Columbia, and the territories and commonwealths. In 2003, there were 890 health center grantees who provided services through 3,600 comprehensive health care delivery sites. The statute requires that grants be awarded in a way that ensures rural populations receive no less than 40 percent or no more than 60 percent of total grants awarded. Applicants for grant funds self-declare their rural status, and in 2003 about 50 percent of the 890 grantees were in rural areas. Because site-level data is not available, it is unclear how many of the 3,600 health center sites are rural versus urban.

By definition, health centers must be located in federally designated MUAs or serve federally designated MUPs. A community or facility must be proactive and seek out the designation by contacting the state primary care office, which submits an application to HRSA. Applicants must define a rational service area, which is typically a county, a group of contiguous counties within 30 minutes’ travel time of each other, a portion of a county depending on market and transportation patterns, or a neighborhood in a metropolitan area defined by its homogeneous socioeconomic and demographic characteristics.

The criteria for designating a community as medically underserved are designed to capture community need from a variety of perspectives including: existing primary care capacity, health status, economic vulnerability, and demand for care. These dimensions of need are quantified in the Index of Medical Underservice (IMU), which is calculated from four data variables:

- Ratio of primary medical care physicians per 1,000 population
- Infant mortality rate
- Percentage of the population with incomes below the poverty level
- Percentage of the population age 65 or over

The four variables are weighted with the most emphasis placed on the primary care provider-to-population ratio. The other variables receive decreasing weights, in the order listed above. These weighted variables are converted into an IMU score from 1 to 100. An IMU score of 62 or lower qualifies the applicant as an MUA/MUP. HRSA does allow some flexibility in the designation process, however. Governors may request designation of a part of their state as an MUA/MUP if it does not meet the 62 IMU score threshold but can still demonstrate significant barriers to care.
WHOM DO HEALTH CENTERS SERVE?

In general, health centers serve a low-income, predominantly female, relatively young population. Ninety-three percent of patients are under age 65. However, the percentage of older working-age adults (45 through 64) seeking care at health centers has been growing in recent years (Figure 1). The health center population is also racially, ethnically, and linguistically diverse; almost two-thirds of health center patients are members of racial or ethnic minority groups, and 30 percent of patients are best served in languages other than English (Figure 2).

Health centers also serve a mostly low-income population. In 2003, 69 percent of health center patients lived at or below 100 percent of the federal poverty level and 90 percent lived at or below 200 percent of the federal poverty level. Health center patients are also much less likely than the general population to have an insurance source and, when insured, they rely heavily on public insurance programs like Medicaid. In 2003, health centers served about 5 million uninsured patients, just over 10 percent of the estimated 45 million uninsured people nationwide.

Aggregate information on health center patients, staff size and composition, utilization, financing, and other characteristics is available through the Uniform Data System (UDS) on a calendar year basis. All health centers are required to submit such data electronically each year to HRSA’s contractor who maintains the UDS. Data is available at the grantee level, not at the level of a grantee’s individual delivery sites, limiting its utility to some extent. Look-alikes and tribal FQHCs do not currently participate in the UDS, and as a result much less information is available about their patient populations and practices.

FIGURE 1
Health Center Patients by Age Group, 2003


WHAT SERVICES DO HEALTH CENTERS PROVIDE?

The ambulatory care services offered by health centers reflect the diverse needs of the population they serve. The combination of a young and predominantly female patient population (59 percent) creates a high demand for obstetric/gynecologic, family practice, and pediatric services. Because of the combination of low incomes, linguistic barriers, and often poor health status, health center patients require access to comprehensive primary care as well as enabling services. Health centers are unique among primary care providers for the array of enabling services they offer, including case management, translation, transportation, outreach, eligibility assistance, and health education.
Although patients served by health centers tend to be young, their incidence of chronic conditions, like diabetes and hypertension, is disproportionate in comparison to the general population. As a result, health centers commit significant resources to managing these chronic conditions.

In many areas, health centers are the sole providers of dental, mental health, and substance abuse services for medically underserved individuals and families. Close to 75 percent of health center grantees provide preventive dental services at one of their sites. Seventy percent provide mental health treatment and counseling, and 50 percent provide substance abuse treatment and counseling on-site. In cases where health centers do not offer services on-site or where demand exceeds on-site capacity, referrals are made to other providers and the health center pays for those services some of the time.

About one-third of health centers have a licensed pharmacy staffed by a pharmacist either in-house or through a contractual arrangement with a local pharmacy. Sixty percent of health centers rely solely on their physicians to dispense prescription drugs. Federal and manufacturer-sponsored programs exist to help health centers make affordable prescription drugs available to their patients. Health centers, look-alikes, tribal FQHCS, and RHCs, among other provider types, can receive significant discounts on outpatient prescription drugs through the federal 340B discount drug program. Drug manufacturers are statutorily required to participate in the 340B program in order to have their drugs reimbursed by Medicaid. HRSA administers the 340B program and contracts with a “prime vendor” or preferred wholesaler who works with the drug manufacturers to negotiate significant discounts and assists entities participating in the 340B program in receiving their orders. In general, 340B drug prices have been found to be about 50 percent of the average wholesale price (AWP).¹⁵

Just over half of health center grantees take advantage of the drug discounts available through the 340B program. It is not entirely clear why more health centers do not participate in the program. There appears to be confusion about the extent to which health centers are allowed to rely on contractual arrangements with local pharmacies versus creating in-house pharmacies, a more expensive undertaking. HRSA maintains that contracted pharmacies have always been allowed, but health centers did not seem to know this was an option until the last few years. There appears to be growing acceptance of the contractual approach,
which explains the recent uptake in the 340B program among health center grantees. HRSA encourages participation in the 340B program by providing technical assistance to grantees as well as competitively funding grants to establish pharmacy networks across several grantees.

The services offered by an individual health center will likely be customized to the needs of the population it serves. Specialized programs, such as Health Care for the Homeless grantees, will tailor their service offerings to the unique needs of their patients. For example, this type of grantee might utilize mobile vans as a base for service delivery, whereas a community health center is more likely to rely on a traditional structure for their clinic.

**WHAT TYPES OF PROVIDERS DELIVER CARE IN HEALTH CENTERS?**

Health centers are staffed by a combination of clinical, enabling, and administrative personnel. They are typically managed by a chief executive officer, a chief financial officer, and a clinical director. Depending on the size of the patient population, the clinical staff consists of a mixture of primary care physicians, nurse practitioners, physician assistants, nurses, substance abuse and mental health specialists, dentists, hygienists, and other health professionals.

Health centers face numerous challenges in recruiting and retaining staff. Health centers are located in areas that often do not attract health care professionals; they serve needy, vulnerable patients; and generally they do not have the financial resources to offer competitive salaries. In response, the federal government has developed several programs to help health centers and other providers in underserved communities to meet their workforce needs.

**National Health Service Corps Program**

The National Health Service Corps (NHSC) provides scholarships and loan repayments to health professionals in exchange for a commitment to practice full-time in a Health Professional Shortage Area (HPSA). The HPSA designation is similar to an MUA or MUP designation, but a HPSA is based solely on a service area’s physician-to-population ratio (see text box). NHSC scholarship recipients receive tuition and fees, books, supplies, equipment, and a monthly stipend for up to four years. They must serve one year for every year of financial support received, with a two-year service minimum. Scholarships are awarded to students enrolled in medical schools, nurse practitioner programs, nurse-midwifery programs, physician assistant programs, and dental schools.

The loan repayment program targets already trained health professionals. It is open to the same providers as the scholarship program as well as to dental hygienists, clinical or counseling psychologists, clinical social workers, licensed professional counselors, marriage and family therapists,
and psychiatric nurse specialists. For a two-year minimum service commitment, the NHSC will pay up to $50,000 of the provider’s qualifying educational loans, plus a 39 percent tax assistance payment. In 2003, 731 of the approximately 11,000 full-time equivalent clinical staff in health centers were NHSC assignees.

### J-1 Visa Waiver Program

Recruiting foreign medical graduates is another way underserved communities (especially rural ones) meet their health care workforce needs. Many foreign medical graduates come to the United States on a J-1 visa to pursue graduate medical education. Upon completion of their residency programs, they are required to return to their country of legal residence for at least two years to share the knowledge and experience they have gained. In some cases, the two-year return home requirement may be waived if an interested government agency (IGA) requests a waiver for the physician.

The J-1 visa–holding physician must have a contract to serve as a full-time, primary care provider for three years in a HPSA or MUA/MUP in order to have the return home requirement waived. A waiver request must be sent by the IGA to the Department of State, who reviews it and forwards it to the Department of Homeland Security (DHS) for final approval. If approved, the J-1 visa converts to an H1B visa. The Conrad 30 Program is a similar program in which state offices of primary care serve as the IGA and may request up to 30 waivers each year per state for J-1 visa physicians to work in HPSAs and MUA/MUPs in their state.

No data are available to quantify the extent to which health centers rely on former NHSC providers or J-1 visas to meet their workforce needs. HRSA recently surveyed health center directors about workforce issues, including gathering information on NHSC and J-1 providers, and expects to release the results in the fall of 2004.
Malpractice Coverage
Through the Federal Tort Claims Act

The federal government also supports health centers’ ability to secure health care professionals through special malpractice coverage. Until 1992, health centers had to purchase private malpractice insurance to protect themselves from malpractice judgments. That year, Congress brought employees of qualifying health centers under the protective liability coverage provided to federal agencies and employees through the Federal Tort Claims Act (FTCA). In essence, malpractice liability is shifted from the individual health center to the federal government, with the costs paid out of the federal health center program’s annual appropriation.

In order to receive FTCA coverage, health centers must apply to HRSA to be designated a “deemed” organization. The deeming process covers credentialing of health center providers, the health center’s risk management systems, and the center’s past claims history. Once a center is deemed, any officer, governing board member, or employee of the health center is covered by the FTCA. In 2003, 77 percent of health center grantees were deemed under the FTCA.

Each year Congress earmarks a portion of its appropriation for health centers for HRSA’s Health Center Judgment Fund to cover the cost of judgments and settlements against health centers. FTCA coverage, unlike private insurance policies that limit the insurer’s liability, does not have a monetary limitation for judgments. As of the end of FY 2003, 1,279 claims had been filed against this fund and 224 of them had been paid. Total claims obligations under the program from its beginning in 1993 to the end of FY 2003 were approximately $79 million, whereas total appropriated deposits were $95.7 million. Because there is only a slight margin between the aggregate claims payout level and the Judgment Fund balance, a single large settlement could easily bankrupt the Fund.

Claims and payment obligations have risen significantly since the fund’s inception and have raised concerns about future funding requirements of the program. Despite these concerns, FTCA coverage has proven cost-effective in providing health centers with malpractice coverage. Had FTCA coverage not been in place, health centers would have spent an estimated $1.05 billion on malpractice insurance premiums from 1993 to 2003.

HOW ARE HEALTH CENTERS FINANCED?

Medicaid is the largest source of revenue for health centers, followed by federal grants. Health centers serve about 10 percent of all Medicaid enrollees nationally and, like all other Medicaid providers, were affected by Medicaid’s shift to a managed care delivery system in the 1990s. Although the trend created apprehension among health centers and results have been mixed, overall, health centers have adapted to the change. In
2003, 45 percent of health center Medicaid patients were enrolled in managed care plans, about on par with overall Medicaid managed care enrollment of 50 percent (Figures 3 and 4). With the advent of Medicaid managed care, health centers were most concerned about losing their Medicaid patient base and the Medicaid cost-based reimbursement that helped them serve the uninsured. Health centers generally lost money in their early experiences of contracting and assuming risk for Medicaid managed care patients, and they struggled to meet many requirements such as providing 24-hour coverage. Much of the centers’ losses occurred in states with “1115 waivers” that chose to legally waive cost-based reimbursement for FQHCs under managed care. Recognizing that health centers needed Medicaid payment protections under managed care to stay financially viable and able to serve the uninsured, Congress in 1997 mandated that state Medicaid agencies make a “wrap-around” payment to FQHCs to cover the difference between their costs for providing care and the rates they were receiving from managed care organizations (MCOs). In many states, these payments were not made in a timely fashion, and health centers resorted to litigation to secure them.

Instead of merely contracting with MCOs, some health centers reacted to the shift to Medicaid managed care by forming their own Medicaid managed care plans. This move preserved their patient base and allowed them greater control over the funding stream. Initially, commercial plans dominated the Medicaid managed care market, but many have since exited for various reasons and plans that focus on Medicaid beneficiaries have gained prominence. Much of the success of Medicaid-focused plans has been attributed to their prior experience with and understanding of the complexities of serving the Medicaid population. The number of Medicaid-focused plans has remained relatively steady since 1996,
but membership has expanded; Currently, 18 community health center–affiliated health plans serve 1.3 million enrollees.

A number of health centers also participate in networks with other health centers or other safety net providers to jointly negotiate contracts with MCOs, centralize some services, and pool resources. HRSA has stimulated these efforts by providing some grant funds through the Integrated Services Development Initiative (ISDI), which began in 1994. Network grantees focus on integrating a chosen area—like financial, pharmacy, or information systems—across members.

The Mechanics of Medicaid Cost-Based Reimbursement

Since 1990, the hallmark of being an FQHC has been cost-based reimbursement for services provided to Medicaid patients. This preferential payment policy helps ensure adequate reimbursement for care provided to Medicare and Medicaid beneficiaries, thus allowing federal and other grant funds to be used to provide care to the uninsured. But cost-based reimbursement systems have their critics. For state Medicaid agencies, cost-based reimbursement rates for FQHCs are higher than the rates they pay other providers and it raises accountability and efficiency concerns; some believe it creates a disincentive to control costs. Consequently, cost-based reimbursement for FQHCs has been threatened in the past; in 1997 Congress passed a law that began to phase it out. Advocates protested the phase-out and in response Congress created a prospective payment system (PPS) for Medicaid payments to FQHCs, which became effective in 2001.

Medicaid cost-based payments for FQHCs were based on the clinics’ overall costs, not the costs of providing care to Medicaid patients alone. Under the cost-based system, FQHCs totaled their annual allowable costs, such as personnel, mortgage, utilities, transportation, and supplies, and divided that by their total encounters with patients to get a cost-per-encounter rate. States reviewed the cost reports to determine which costs were allowable; Medicaid programs had to follow Medicare statute and regulations in determining allowable costs and reasonableness of costs. States could set their own limits for reasonableness of costs, including setting ceilings on costs per service or a limit on a certain type of cost. In a given year, an FQHC was paid based on the previous year’s per encounter rate and underwent a reconciliation process at the end of the year—once cost reports had been audited—to reimburse it for any underpayment or overpayment by the state. Because the calculation was based on total costs, it did not reflect any difference in utilization by or resource intensiveness of Medicaid patients relative to other types of patients.

The current PPS is a less generous Medicaid payment methodology than cost-based because it is tied to the average of each FQHC’s allowable costs from FY 1999 and FY 2000. Medicaid agencies started using the PPS to pay for services provided on or after January 1, 2001. For services provided in FY 2002 and each subsequent year, each FQHC’s per-encounter
rate is adjusted for inflation by the Medicare Economic Index (MEI) for primary care. The MEI is considered a historically low measure of inflation and “an FQHC’s...ability to manage under the new PPS will depend on its initial payment rate, and changes it can make to keep its cost growth at or below the inflation index.” In general, states prefer the PPS because it limits their payments to FQHCs and is a more predictable expense. It also eliminates the annual cost report auditing required by a cost-based system, which is resource-intensive. As with cost-based reimbursement before, under the new PPS states must pay FQHCs a wrap-around payment for the difference between their per-encounter rate and the payment they receive from MCOs.

Notwithstanding these benefits of the PPS, states must strike a balance between saving money in the short term through lower Medicaid payments with a PPS and spending money in the long term if a health center becomes insolvent and therefore cannot care for Medicaid or uninsured patients, causing patients to revert to emergency room–based care. Some states have therefore chosen to take advantage of a provision in the Medicaid statute that allows them to reimburse FQHCs more generously than the PPS by implementing an alternative payment methodology. The alternative must pay at least what the FQHC would receive under the PPS and must be agreed to by the FQHC. Based on a 2003 survey, 15 states have maintained cost-based reimbursement as their alternative payment methodology. A few others are implementing a PPS using more recent costs than those from FY 1999 and 2000 or are using more generous inflators. Both Maryland and Florida are implementing the PPS and are using the MEI as the inflator, rather than an alternative payment methodology. Maryland’s Medicaid program pays FQHCs between $90.71 and $191.24 for medical visits and $78.90 to $171.53 for dental visits under the standard PPS formula. By comparison, Florida’s Medicaid program pays FQHCs between $78.70 to $125.86 per visit, including dental payment.

It is unclear whether the shift to a PPS has had a negative impact on the general financial viability of health centers. In the aggregate, Medicaid revenues to health centers have been increasing each year, before the PPS implementation and after. To date, most analysis of the PPS has focused on determining where it is being implemented and how. Some clarity may come from a report requested by Congress in the same law that authorized the PPS. Congress charged the U.S. General Accounting Office (renamed the Government Accountability Office in July 2004) with studying the need and method for re-basing or refining costs for determining Medicaid payment to FQHCs; the GAO is in the preliminary phase of conducting this study.

Grant Funds

Despite aggregate funding increases to the health centers grant program over the last decade, dollars per uninsured patient have remained flat. In
In 1995, health centers received $249 per uninsured patient compared to about $268 per uninsured patient in 2003. These grant dollars are critical to health centers to enable them to provide care to the uninsured as well as pay for enabling services, but they are not enough to cover those costs entirely. In 2003, the total cost per patient averaged about $479. In real 2003 dollars, the annual rate of growth of federal appropriations for health centers was 7.3 percent between FY 2002 and FY 2003, but the estimated growth in the number of uninsured health center patients over that same period was 11.4 percent.

To make up for this gap in funding, health center administrators leverage their dollars from grant, Medicaid, and other sources to cover the costs of care to the uninsured. The George W. Bush administration has increased overall appropriations for the health centers program (Table 1), but for FY 2004 about three-quarters of it has been targeted to funding new health centers, additional delivery sites at existing centers, and expanding capacity to serve more patients, with only one-quarter dedicated to increasing the amount existing centers receive.

Many health centers also rely on state, local, and private grants and donations to supplement Medicaid reimbursements and federal grant funds that, in general, are not keeping up with health care cost inflation. Many states have cut grant funds to health centers during the last few years of state budget crises. According to a survey conducted by the National Association of Community Health Centers, 17 of 31 states that provided direct funding to health centers in 2003 cut that funding by more than $40 million, or about 7 percent of total state and local grant funding to health centers. Larger state funding cuts were anticipated but did not materialize, in large part because of the $20 billion in federal fiscal relief states received from the Jobs and Growth Tax Relief Reconciliation Act of 2003. However, the cuts implemented were not insignificant and tightened health center margins, which can easily shift from black to red.

### Private Health Insurance

In general, health centers do not generate a significant amount of revenue from privately insured patients. In 2003, 15 percent of health center patients were privately insured, but only 6 percent of health center revenues came from private insurance. These privately insured patients could be lower utilizers of care, but it is more likely, considering the low income level of the majority of health center patients, that the private insurance policies they had were high-deductible plans that offered limited benefits and paid low rates. By comparison, 36 percent of health center patients were covered by Medicaid and 36 percent of health center revenues come from Medicaid. If many Medicaid-covered patients were to shift to private insurance coverage, it could negatively impact health centers’ ability to serve the uninsured.

### TABLE 1

<table>
<thead>
<tr>
<th>Fiscal Years 1994–2004</th>
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<tbody>
<tr>
<td><strong>FY</strong></td>
<td><strong>$ Billions</strong></td>
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<tr>
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<tr>
<td>2000</td>
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<tr>
<td>2001</td>
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</tr>
<tr>
<td>2002</td>
<td>1.34</td>
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<td>1.47</td>
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<td>2004</td>
<td>1.57</td>
</tr>
<tr>
<td>2005</td>
<td>1.79 *</td>
</tr>
</tbody>
</table>

*President’s Budget Request.

Source: Bureau of Primary Health Care, Health Resources and Services Administration, DHHS.
Medicare

Medicare is a relatively small revenue source for health centers. Like Medicaid, it has special payment provisions for FQHCs. Medicare services are paid on an all-inclusive, per-encounter rate but are capped by an upper payment limit set by CMS. Each FQHC has its own encounter rate derived from its prior year total allowable costs (dental, pharmacy, and optometry costs are excluded), divided by total encounters. Beneficiaries pay a coinsurance of 20 percent of the per-encounter charge and Medicare pays 80 percent. For the 80 percent it reimburses the center, Medicare will not pay above $106.58 for urban FQHCs and $91.64 for rural FQHCs. Health centers must absorb any costs above these levels. CMS’s fiscal intermediary for FQHCs estimates that 60 percent of FQHCs have hit this upper payment limit. Medicare does not reimburse FQHCs for some preventive services that FQHCs typically provide because they are excluded by Medicare law; examples include preventive dental services and health education classes. However, for eligible FQHC services, no Medicare Part B deductible applies.36

The Bottom Line

With the many changes in the health care environment affecting health centers over the last decade—the shift from cost-based reimbursement to a PPS, the increasing prevalence of managed care delivery systems in Medicaid, increasing numbers of uninsured patients, flat per–uninsured patient grant funding, and state budget shortfalls—it would seem that health centers would be under significant financial stress, and some are. According to HRSA’s analysis, approximately 4 percent of health centers have financial, organizational, or managerial problems that seriously threaten their stability and viability. About half of those have sound internal management and operational systems but are facing external market changes (for example, an increase in uninsured patients due to a local economic downturn) that are negatively impacting their viability.37 Achieving financial stability and growth in the midst of such a complex and rapidly changing health care market requires astute health center leadership and expertise beyond merely balancing costs with revenues. Factors such as productivity, operations, information technology, and access to capital, among others, all contribute significantly to the overall balance sheet.

HOW DO HEALTH CENTERS ENSURE HIGH-QUALITY CARE?

Health centers were patient-centered and focused on improving the quality of care long before these terms became industry buzz words. Despite the financial pressures they face, multiple studies document health centers’ efficacy in reducing the delivery of low birth weight babies, reducing hospitalizations for patients with chronic conditions, and providing
preventive women’s health services. For example, a comparison of health center and national data showed that 10.3 percent of African American women served by health centers deliver low birth weight babies, compared to 13.1 percent of African American women nationally. The rate for rural African American women served by health centers and delivering low birth weight babies was even lower: 8.5 percent, compared to 13.0 percent for all rural African American women.38

Another study compared hospitalization and emergency visits for a set of chronic and acute conditions across 50,000 Medicaid beneficiaries, some of whom received the majority of their care from FQHCs and others who received their care from office-based providers or other outpatient settings in the same areas. It found that beneficiaries “who received most of their primary care from FQHCs were significantly less likely to be hospitalized and less likely to seek ER care for ACSC [ambulatory care sensitive conditions] than a comparison group.”39

Performance Review and Accreditation

The most basic way HRSA assures health center quality is by reviewing grantee performance before renewing their grant funding (usually every 3 to 5 years). Until recently, the agency conducted a Primary Care Effectiveness Review (PCER) that was mostly compliance-oriented. The PCER was phased out in December 2003 and has been replaced by the Performance Review Protocol. The new process aims to be more performance than compliance-oriented and will be conducted by teams of mostly federal reviewers from HRSA’s ten field offices. For example, the new process will include a review of data capacity and systems and their use. A standard list of performance measures for health centers is unavailable because the new process is in its early stages.

About one-third of health center grantees have been accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).40 HRSA began working with the JCAHO in 1996 to combine the PCER with JCAHO’s accreditation survey for ambulatory care organizations. With the introduction of the new review protocol, HRSA is reviewing its relationship with the JCAHO and considering how and when to review JCAHO-accredited health centers in the future.

Improving Clinical Care Processes

Although health centers’ effectiveness as providers of care to vulnerable populations is well documented, the patients they serve have diverse needs and there remain disparities in health status between health center patients and the general population. In a continued effort to reduce and eliminate these disparities, HRSA’s BPHC implemented a series of health disparity collaboratives, beginning in 1998 with an effort to improve diabetes health outcomes and diabetes clinical practice. The collaboratives

Multiple studies document health centers’ efficacy in providing quality care.
are the result of a partnership between BPHC, the Institute for Healthcare Improvement, and the MacColl Institute for Healthcare Innovation. Their goal is to change the way health centers manage chronic diseases by improving their delivery system, encouraging more self-management by patients, and utilizing clinical information systems for decision making.

Though national evaluations of the collaboratives are currently underway, none has yet been completed or published, but one regional study found that the interventions performed as a result of the diabetes collaborative did improve the number of patients receiving care according to the American Diabetes Association’s clinical practice recommendations. The study reviewed charts and surveyed and interviewed providers and staff in 19 Midwestern health centers who participated in the collaborative in 1999. It found that HbA1c measurement (a blood test that measures the average blood sugar level during the past few months), eye examination referral, foot examination, nutrition counseling, and other care processes improved for diabetic patients as a result of the collaborative.41

Since April 2000, according to HRSA, average HbA1c values for patients in the diabetes registry have fallen from almost 8.8 to 8.1 as the registry grew from about 22,000 to 92,000 patients. Such reduction could be significant, as suggested by the United Kingdom Prospective Diabetes Study which found that a nearly 1.0 percent reduction in HbA1c results in a 17 percent reduction in mortality, a 15 percent reduction in stroke, and an 18 percent reduction in heart attacks.42

HRSA helps defray the costs to health centers for the intensive first year of a collaborative. Beyond the first year, health centers may compete for grants of about $40,000 to continue and expand collaborative efforts. Additional collaboratives targeting asthma, depression, cardiovascular disease, cancer, and HIV/AIDS have been added since the initial diabetes collaborative. Currently over 500 health centers are participating in health disparities collaboratives involving over 180,000 patients. HRSA is working on prototypes for four new collaboratives: prevention, redesigning the office practice, perinatal care, and diabetes prevention. HRSA and the Agency for Healthcare Research and Quality are collaborating on a multi-year, national evaluation of the collaboratives that is expected to be available in late 2005.43

Despite documented success in providing care to underserved populations, centers face challenges in their ability to ensure access to specialty care and diagnostic tests for their uninsured populations. In order to receive grant funds, health centers must establish formal referral relationships for specialty care, diagnostic services, nonemergency hospitalizations, and other care not provided by the center. Despite these requirements, they face limitations in providing meaningful referrals for their uninsured patients. One survey of 20 health center executive directors and medical directors from ten states found that they could “obtain specialty referrals for their insured patients ‘frequently’ or ‘very frequently’” but only 59 percent could do so as often for uninsured patients.”44
It is worth noting that HRSA’s preliminary analysis of the 2002 health center visit survey, a review of a representative sample of health center patient medical records, shows that only 7.5 percent of patient visits resulted in hospitalization or specialty referral.\textsuperscript{45} However, for the minority of patients who do need to consult with a specialist or have access to a diagnostic imaging test, these barriers to care can have significant consequences.

Some health centers are partnering with other primary care providers to draw on their resources to provide specialty care to their uninsured patients. In some communities, health centers are working with free clinics to take advantage of their referral networks. Other health centers have become part of community consortia that apply to HRSA for a Healthy Communities Access Program (HCAP) grant. HCAP grants are designed to help communities better coordinate their health care system for the uninsured. For many health center grantees, that means establishing a network of specialty care providers willing to see uninsured patients as well as managing the number of uninsured patients sent to each provider to ensure their continued participation.

**WHAT HAS BEEN THE IMPACT OF THE RECENT HEALTH CENTER EXPANSION INITIATIVE?**

The health centers’ long track record of providing cost-effective care to underserved populations led the Bush administration to expand health centers as a key component of its strategy to address the uninsured. In FY 2002, the administration launched the President’s Health Centers Initiative with the goal of adding 1,200 new and expanded health center sites over five years and to “ultimately double the number of patients treated” at health centers.\textsuperscript{46} Due to budget pressures, the goal of the initiative has shifted to increasing “the number of patients served annually from about 10.3 million in 2001 to 16 million by 2006.”\textsuperscript{47}

To meet the expansion goal, HRSA’s BPHC administers three grant competitions: new access points, expanded medical capacity, and service expansion.

- The **new access point** competition provides funding for an entirely new grantee or for an existing grantee to open a new site. Individual awards are capped at $650,000 for FY 2004.
- The **expanded medical capacity** competition increases an existing health center’s ability to serve more people at existing sites. Individual awards are capped at $600,000 for FY 2004.
- The **service expansion** competition seeks to add new or expanded mental health, substance abuse, or oral health services and to fund continued participation in health disparities collaboratives. These individual awards are capped at $250,000 for oral health expansions where it is a new service, $150,000 for oral health expansions where it is an existing service, $150,000 for new and existing mental health/substance abuse expansions, and $40,000 for health disparities collaboratives.
The expanded medical capacity and service expansion competitions are limited to existing grantees, so the only way new organizations may receive funding is through the new access point competition. Typically, HRSA will run two to three application cycles for new access points and one cycle for expanded medical capacity and service expansion in a fiscal year.

All applications for each of the three competitions are evaluated by an Independent Review Committee (IRC) comprised of federal and nonfederal experts. The IRC makes recommendations on the merits of each application, but HRSA program officials ultimately make the grant award decisions. All grant awards for health centers must be made in such a way to ensure that rural populations receive no less than 40 percent or no more than 60 percent of grant funds and to ensure that awards to the migrant, public housing, and homeless programs are made in the same proportion of the total appropriation as in FY 2001.

In order to effectively assess community need and to ensure readiness to serve patients within 90 to 120 days of grant award, the application process is extensive and complicated. BPHC imposes certain screens and preferences in deciding which applications will be reviewed and which will receive funding. For example, new access point applicants are encouraged to submit a letter of interest describing the level of community need for additional primary care services and a brief description of the proposed project, and BPHC provides feedback to those submitting letters to help strengthen their final application. New access point applicants are also screened through a need for assistance worksheet to see if their level of need is high enough to merit formal application review. A funding preference is given to those applicants that serve sparsely populated rural or frontier areas, defined by BPHC as a geographic area with fewer than seven people per square mile.

Recognizing the need to build capacity to compete in this fairly resource-intensive application process, HRSA partners with and provides funding to Primary Care Associations (PCAs) throughout the country. Each state’s PCA analyzes the state’s unmet need for primary care services, works with communities to develop competitive applications to fill that need, and provides technical assistance to existing and expanding health centers. Despite this funding, it is unclear whether the efforts are adequate to jumpstart activities in resource-poor areas.

The Bush administration is on track toward achieving its expansion goal by the end of the five-year period (FY 2006). To date, with almost three of the five fiscal years of the initiative completed, HRSA has created 334 new access points (165 new grantees and 169 new satellite sites) and awarded 285 expanded medical capacity grants, for a total of 619 toward the goal of 1,200 new and expanded sites. Service expansion grants do not factor into these increases because they add or expand services like dental or mental health but do not add new sites or a new patient population. About 3 million new patients have been added during the first three years of the expansion, over half of the goal of adding 5 million new patients in five years.
If sheer volume of applications is any indication, there is substantial desire and need in communities for health center funding. With the first three years of the expansion almost complete, about 600 of 1,600 applications have been awarded (new access point and expanded medical capacity), or 38 percent. The number of applications received and awarded in any given fiscal year is relative because HRSA has been taking some applications received in one fiscal year and awarding them in the next, if they scored well and there was not enough money to fund them in the initial application year. For example, 48 of the 63 new access point awards for FY 2004 thus far were funded from the batch of 468 applications received in FY 2003; the other 15 awards for FY 2004, therefore, were decided from 182 applications—only an 8 percent award rate (Table 2).

**TABLE 2**
Applications and Awards for Health Center Grant Competitions, Fiscal Years 2002 – 2004

<table>
<thead>
<tr>
<th></th>
<th>Received</th>
<th>Awarded</th>
<th>% Awarded</th>
<th>Received</th>
<th>Awarded</th>
<th>% Awarded</th>
<th>Received</th>
<th>Awarded</th>
<th>% Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Access Point</td>
<td>309</td>
<td>171</td>
<td>55%</td>
<td>468</td>
<td>100</td>
<td>21%</td>
<td>182</td>
<td>63</td>
<td>35%</td>
</tr>
<tr>
<td>Expanded Medical Capacity</td>
<td>238</td>
<td>131</td>
<td>55%</td>
<td>182</td>
<td>88</td>
<td>48%</td>
<td>235</td>
<td>66</td>
<td>28%</td>
</tr>
<tr>
<td>Service Expansion</td>
<td>284</td>
<td>203</td>
<td>72%</td>
<td>412</td>
<td>71</td>
<td>17%</td>
<td>pending</td>
<td>pending</td>
<td>pending</td>
</tr>
</tbody>
</table>

FY 2002 FY 2003 FY 2004 Year-to-Date

*Source: Bureau of Primary Health Care, Health Resources and Services Administration, DHHS.*

**Geographic Distribution of Expansion Funds**

Several western states, namely Alaska, North and South Dakota, and Montana, received the biggest increases in BPHC grant dollars relative to their prior funding levels since the expansion effort was initiated (see Appendix). These states historically have had a small number of grantees, so these increases may indicate a move toward a more equitable distribution of funds. However, a detailed analysis of relative funding allocation across states in the context of estimated need (such as numbers of underserved and uninsured persons or percent of population living in an MUA) is not publicly available.

Some states with widely publicized rates of uninsurance, such as Oklahoma, California, and Arizona, were in the top third of states receiving the largest percentage increases in their grant awards, but other states with high percentages of uninsured people like Florida, Texas, and Louisiana,
were in the bottom third. Because the health centers’ mission is to provide access to care for medically underserved populations—not just the uninsured—looking at changes in uninsured patients by state is an imperfect way of assessing impact, but data on changes in underserved populations by state are not available.

HRSA has conducted its own internal analysis which shows that states with the lowest health center penetration relative to their unserved populations before the expansion—Georgia, Texas, North Carolina, and North Dakota—have set the most ambitious expansion goals for health center penetration and are meeting their targets after the first two years. Although these findings are heartening, further analyses of the placement and impact of the expansion grants appear warranted and merit broad dissemination.

Workforce Implications

The expansion to 1,200 new and expanded sites will require 36,000 additional personnel including 11,000 new clinicians. The Bush administration has requested budget increases in the range of 10 to 20 percent for the NHSC for each year of the health centers’ expansion. Funding the NHSC scholarship program creates a timing problem because scholarship recipients will not be ready to serve for up to seven years. In light of this reality, the NHSC is targeting most of its funds to loan repayment for ready-to-serve providers, which will increase total NHSC clinicians in the field to about 4,000 in FY 2004.

This is an historic high for the program, but it will likely yield limited impact on health centers’ workforce needs. Typically, half of NHSC providers serve in health centers, which equates to approximately 2,000 providers available for the 3,600 existing comprehensive health center sites, plus any new sites that are added during the FY 2004 grantmaking process. DHHS is also using its participation as an IGA for the J-1 visa waiver program to target physicians to health centers in HPSAs of greatest need, but their participation will amount to less than 25 applications for placement in FY 2004.

Even with these federal efforts, it appears that a significant workforce gap at health centers remains. According to preliminary results from a 2004 HRSA-sponsored survey of health center directors, about 70 percent of health centers can fill their clinician vacancies within 6 months and approximately 90 percent of health centers can fill them within a year.

WHAT FUTURE POLICY CHANGES ARE IN STORE FOR HEALTH CENTERS?

The 330 grant program is both popular and successful. Health centers have proven to be an effective investment of federal funds, have garnered sustained goodwill and advocacy in the communities they serve, and, as a result, generally have enjoyed broad, bipartisan support. The wide appeal and positive results of health centers have made many reluctant
to raise questions or concerns that could be perceived as criticisms of the 330 grant program. Internal scrutiny of the program by HRSA has certainly taken place, as evidenced by grantee performance monitoring and management initiatives aimed at improving program operations and health center effectiveness. Furthermore, the health center expansion is a top priority of the Bush administration, and progress in meeting the goals of its initiative has been closely monitored and widely shared. However, public discourse and legislative debate related to structural and substantive changes in the health center program have been very limited.

Although there are no loud calls for a substantial policy overhaul, the recent expansion of community health centers has brought attention to a number of policy concerns. Chief among these are questions related to whether 330 grant funds, and expansion funds in particular, are being targeted to communities with the greatest need. These concerns involve perceived deficiencies in the empiric measures of need, as well as reservations regarding the competitive process used to make grant awards.

**Measures of Underservice**

The first hurdle communities face in qualifying for health center grant funds is becoming designated as a medically underserved area (MUA) on the basis of the Index of Medical Underservice (IMU). Critics argue that this index is not an accurate reflection of need for a variety of reasons, including:

- **Insurance status is not addressed.** Although the existing measure addresses income level, it does not explicitly reflect health insurance status. Some argue that incorporating rates of uninsurance and Medicaid coverage levels into the IMU would help target funds to the neediest places. Others counter that such an approach could establish perverse incentives for state policy makers and question the feasibility of collecting community-level data on insurance status for MUA designation.

- **Provider ratios do not serve as a reliable access proxy.** Some argue that traditional physician-to-population ratios have little relationship to the accessibility of care. Provider willingness to serve the uninsured or Medicaid patients is likely to vary across communities, and these differences fail to emerge in the existing measure. Although this weakness may result in an overestimation of available capacity in some communities, other concerns involve possible underestimation of capacity. Some have suggested that nonphysician providers, an increasingly important source of primary care, should be included in these calculations. Others point out that reliable data sources for these provider types do not exist at the community level and that gathering such data would be expensive.

- **Infant mortality may not reliably predict health service needs for some populations.** Infant mortality reflects a wide variety of threats to community health, including environmental, nutritional, medical, and
societal risks. Some argue that the broad nature of this measure makes it an imperfect predictor of the need for medical care. These critics often note that Hispanics have a lower infant mortality rate than Whites or African Americans but have the highest rate of uninsurance.

In response to these criticisms and other concerns, DHHS is considering a change to the MUA designation criteria that could involve merging the MUA/MUP and HPSA measures. The department attempted to combine the measures in the mid-1990s and published a proposed regulation, but there was so much criticism of it that a final regulation was never published. Because over 30 federal programs tie their eligibility or funding preference to HPSA and MUA/MUP designations, making any attempt to change the process politically sensitive, given the likelihood that some communities could lose their designations and their funding.

The new proposed regulation is likely to suggest some key changes such as recognizing the special needs of frontier areas, providing a broader set of proxies for health status beyond infant mortality, and counting the contributions of nonphysician providers. The draft regulation is currently undergoing review within DHHS, and a projected date of its publication has not been made public.

**Competitive Award Process**

Some argue that HRSA’s application and review processes further compound the inadequacies of the empiric measures used to establish MUAs. Although few question the integrity of the process, many feel a competitive approach is not appropriate for directing funds to vulnerable, resource-poor communities. The competitive nature of the process ensures that award decisions are favored toward organizations able to put together an application, how well they can make their case regarding community need, and their readiness to utilize the grant award.

Managing a health center requires significant financing, workforce, operations, management, and governance savvy. As stewards of federal funds, HRSA wants to award grants to organizations that are capable of providing high-quality care in a complex health care marketplace and, understandably, has crafted a grant award process that rigorously tests the readiness of potential grantees.

Concerns have been raised that this approach is not effective in channeling funds to areas of greatest need, but instead to areas with stronger safety nets made up of more sophisticated organizations that have the resources to secure professional grantwriters and good data analyses.

According to a recent analysis of the safety net in 12 communities across the United States, communities with larger, stronger safety nets competed most successfully for HRSA grant funds. The study found that the application and review process rewards financially stable organizations with the infrastructure and leadership to prepare successful grant applications, not those most in need of funding.
Critics argue that the process should target the neediest areas by linking dollars more explicitly to objective measures of need. For example, some have suggested that the award process should take into account the relative generosity of a state’s Medicaid program and prioritize areas with growing uninsured populations. Others respond that increasing awards to applicants in states with less generous Medicaid programs might create a disincentive for states to expand their Medicaid programs or to pursue alternative coverage expansion strategies.

**Relationship Between 330 Grants, Medicaid, and Public Insurance Coverage Policies**

Policy decisions regarding health centers are closely linked to dynamics within the Medicaid program and other efforts influencing insurance coverage levels. Health center financial viability is a delicate balance of Medicaid reimbursements, federal grant funds, and state and local grant funds. Some health centers are struggling to balance a mission and mandate to provide care to anyone who walks through their door regardless of ability to pay with the reality of tight fiscal environments at the national, state, and local levels.

Many state legislatures are approving Medicaid benefit and eligibility cuts in an effort to balance their budgets. Others are considering major Medicaid demonstration waivers that would fundamentally reform their Medicaid programs by capping enrollment, creating waiting lists, and reducing benefits, among other cost-containment strategies. Although reimbursement rates for health centers are currently protected through the PPS and total Medicaid revenues to health centers have been steadily increasing each year, the financial stability of health centers could be jeopardized if a significant number of health center patients were to lose their Medicaid eligibility.

Recent trends suggest that health centers are experiencing growth in the number of uninsured patients served as federal grant amounts per uninsured patient remain flat. Some states and localities are reducing grant funding to health centers, forcing them to reduce enabling services like outreach and enrollment that might otherwise draw additional revenues from Medicaid and SCHIP (State Children’s Health Insurance Program). Health centers are also facing significant increases in health care premiums and workers’ compensation costs for their own employees.

As a result of these fiscal challenges, many argue that the pre-expansion health centers, “the base,” deserve more attention and resources to ensure their continued viability. Policymakers have acknowledged the needs of existing health centers. In FY 2004, Congress directed HRSA to set aside $25 million for base adjustments to existing grantees. With the remainder of the appropriation, HRSA has budgeted $37 million for new starts and new access points, $26 million for expanded medical capacity, and $7 million for service expansions. There is debate over whether $25 million is adequate to cover the rising number of uninsured patients and increasing

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**Health center financial viability is a delicate balance of Medicaid reimbursements, federal grant funds, and state and local grant funds.**
costs of providing care that pre-expansion health centers are experiencing. Some believe the Bush administration may achieve the goals of the expansion in the short-term but that ultimately access and service may deteriorate without more attention to the viability of existing grantees. More objective analyses are needed on this issue.

**Alternative Models for Safety Net Services**

Concerns have also been raised that current federal support for primary care services, as embodied in the health center program, does not adequately address the contribution of provider groups that do not conform to the health center model. Primary care clinics run by religious organizations, hospital outpatient departments, and local governments generally are not eligible for 330 funding due to the governance requirements of the grant. Because the existing primary care safety net in some communities is composed entirely of these ineligible providers, many communities face a dilemma in securing federal funds. They can opt to forgo such funding or establish a 330-funded clinic that may duplicate, and potentially undermine, existing capacity.

In May 2004, the Senate Republican Task Force on Health Care Costs and the Uninsured released a number of proposals to control health care costs and decrease the uninsured population. These proposals included a provision to allow religious-sponsored health systems to qualify for 330 funding by exempting them from the statutory governance and ownership requirements. Critics of this approach maintain that the community-based governing board is a central element of the health center program and that the exemption would subvert this defining characteristic.

Others believe the exemption should be expanded to include other types of ineligible organizations. Some observers question the priorities of ineligible provider groups. While health centers seek to provide a true medical home and an ongoing relationship with a clinician, other types of safety net providers, like some hospital outpatient departments, may be more focused on training a rotating roster of medical students or providing inpatient care than creating a medical home and arranging enabling services. However, the validity and generalizability of this concern has not been well documented.

Some have suggested that a funding stream separate from the 330 program should be established to support alternative primary care models. Though the health centers’ national trade association has said it would not oppose such an action, these proposals have caused concern among some health center advocates who worry that such an approach would eventually compromise funding for the traditional health center model. These critics also maintain that high levels of federal funding already flow to many of these safety net institutions through the Medicaid disproportionate share hospital (DSH) program.
CONCLUSION

A careful examination of the history and current status of community health centers reveals both inspiring success stories and opportunities for future improvement. Both the projected conclusion of the expansion initiative and the reauthorization of the health center program are slated for FY 2006—in some respects distant on the legislative calendar, in other respects fast approaching. The reliance on the health care safety net by tens of millions of Americans demands a continuing policy focus on the health center grant program. The impact of increasing investments in health centers on access to care and the relationship between health centers and other safety net programs merit ongoing attention and evaluation.

ENDNOTES


2. Health Revenue Sharing and Health Services Act, Public Law 94-63.


4. §330, Public Health Service Act.

5. The consolidated health centers statute does allow for grants to public entities but limits them to no more than 5 percent of the health center appropriation in any fiscal year.

6. Frontier areas are defined in different ways by different parties. HRSA defines them as fewer than seven people per square mile.

7. §330(r)(2)(ii), Public Health Service Act.


14. The 2003 Poverty Guidelines were $8980 for one person and $18,400 for a family of four in the contiguous 48 states and District of Columbia.


17. UDS, “Calendar Year 2003 Data,” rollup summary.


20. UDS, “Calendar Year 2003 Data,” table 9C.


24. Association for Health Center Affiliated Health Plans staff, phone and e-mail communication with author, June 2, 2004.

25. Similarly, the concept of cost-based reimbursement in the Medicare program was phased out and replaced by prospective payment mechanisms in the early to mid-1990s.


27. The MEI is a national weighted average of the annual change in prices for the various inputs used to furnish physician services, like professional liability insurance, physician earnings, employee wages, and rent.


37. Health Resources and Services Administration (HRSA) staff, e-mail communication with author, August 24, 2004.


42. Office of Health Center Development, Bureau of Primary Health Care, HRSA staff, e-mail communication with author, July 12, 2004.

43. HRSA staff, phone communication with author, May 11, 2004; and Agency for Healthcare Research and Quality staff, phone communication with author, August 17, 2004.


45. HRSA staff, e-mail communication with author, August 24, 2004.


48. FY 2004 new access point, expanded medical capacity, and service expansion Program Information Notices (PINs) can be accessed at http://bphc.hrsa.gov/pinspals/pins.htm.

49. HRSA staff, e-mail communication with author, July 12, 2004 and August 24, 2004.

50. HRSA staff, personal communication with author, August 24, 2004.


53. When DHHS serves as an IGA and submits applications on behalf of J-1 visa–holder physicians, the goal is to convert their J-1 visa to an H1B visa, which enables them to skip the return home requirement and practice in a HPSA. The number of H1B visas awarded by the Department of Homeland Security is capped each year. For FY 2004, the cap was 65,000 and it was met by February 2004. Multiple visa types, beyond the J-1 visa, convert to H1B status. Requests for visa conversion from J-1 to H1B by federal IGAs, but not state Conrad 30 requests, are subject to the cap. This has limited DHHS’s ability to facilitate placing foreign physicians in community health centers.

54. HRSA staff, e-mail communication with author, August 24, 2004.

### APPENDIX

Comparison of State Level Health Center Grantee Data for Calendar Years 2001–2003

<table>
<thead>
<tr>
<th>STATE</th>
<th>Grant Money (% Change)</th>
<th>Total Change in Grant Money ($)</th>
<th>Uninsured Users (% Change)</th>
<th>Total Encounters (% Change)</th>
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Appendix– continued
**APPENDIX (continued)**
Comparison of State Level Health Center Grantee Data

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<th>STATE</th>
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<th>Total Change in Grant Money ($)</th>
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*No 2003 UDS data available to calculate change.

Source: Compiled from UDS, State Rollup Reports from “Calendar Year 2003 Data.”
What is Global Health and Why Does it Matter?

Global health is the health of populations—of humanity at large

It is ensuring health and safety millions of people at a time, just as family doctors care for one patient at a time. The Institute of Medicine (IOM), part of the U.S. National Academy of Science has defined global health as referring to ‘health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions.’

Global health is about recognizing that the health problems seen around the globe are also seen in our own backyards. Global health problems need to be directly faced, not only for purely selfish reasons, but because humanity will be better-off because of it. We cannot overstate the reality that problems in remote parts of the globe can no longer be ignored. Diseases that Americans once read about as affecting people in regions of the world that most of us would never visit are now capable of reaching us directly. The hunger, disease, and death resulting from poor food and nutrition create social and political instability in many nations, and that instability may spread to other nations as people migrate to survive. The environmental conditions that poison our water and contaminate our air are not contained within national boundaries, but float on winds and waves to not-so-distant places. Failing to address global health issues outside our national border will only make the problems that much more challenging when they enter our country.

Global health is of fundamental moral, practical, and strategic importance to not only populations abroad, but to Americans as well.

- Caring about the health of others is a moral value shared by people of all cultures and religions. All societies, cultures, and religions value human life. All people harbor compassion that drives us to help those who are suffering or in need. We believe that to allow suffering to continue is inhumane

- Caring about the health of others is also of practical significance because of the interconnectedness of the world and the ability of disease to spread rapidly across borders. Global health grasps that viruses, bacteria, and parasites can cross all borders—so to fight against them must do the same

- Caring about the health of others is of strategic significance since health diplomacy, or working with other nations on shared health goals, promotes international cooperation, is critical to the long-term health and security of the American people. It is the way to protect, promote, and advance the health and safety of the nation. Health diplomacy also acknowledges that poor health contributes to political and economic instability, two factors that threaten world peace.

Christopher Black,

Background and Context: The Role of Primary Care Within Global Health: A Summary of the 2008 World Health Report “Primary Health Care: Now More Than Ever”

The Role of Primary Care Within Global Health:

Primary health care was put forward thirty years ago as a set of values, principles and approaches aimed at raising the level of health in deprived populations. In all countries, it offered a way to improve fairness in access to health care and efficiency in the way resources were used. Primary health care embraced a holistic view of health that went well beyond a narrow medical model. It recognized that many root causes of ill health and disease lie beyond the control of the health sector and thus must be tackled through a broad whole-of-society approach. Doing so would meet several objectives: better health, less disease, greater equity, and vast improvements in the performance of health systems.

Today, health systems, even in the most developed countries, are falling short of these objectives. Although remarkable strides have been made to improve health, combat disease and lengthen life spans, people worldwide are dissatisfied with existing health systems. One of the greatest worries is about the cost of health care. This is a realistic concern since 100 million people fall into poverty each year paying for health care. Millions more are unable to access any health care.

The source of the problem is that health systems and health development agendas have evolved into a patchwork of components. This is evident in the excessive specialization in rich countries and donor-driven, single disease-focused programmes in poor ones. A vast proportion of resources are spent on curative services, neglecting prevention and health promotion that could cut 70% of global disease burden. In short, health systems are unfair, disjointed, inefficient and less effective than they could be. Moreover, without substantial reorienting, today’s struggling health systems are likely to be overwhelmed by the growing challenges of aging populations, pandemics of chronic diseases, new emerging diseases such as SARS, and the impacts of climate change.

“Rather than improving their response capacity and anticipating new challenges, health systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a clear sense of direction,” says World Health Report 2008 entitled Primary Health Care – Now More Than Ever. With the publication of the report on 14 October, WHO hopes to start a global conversation on the effectiveness of primary health care as a way of reorienting national health systems. WHO Director-General, Margaret Chan, wrote in a recent editorial in the journal The Lancet: “Above all, primary health care offer(s) a way to organize the full range of health care, from households to hospitals, with prevention equally important as cure, and with resources invested rationally in the different levels of care.”

Actually, WHO hopes to revive the conversation. Primary health care was officially launched in 1978, when WHO member states signed the Alma Ata Declaration. That was 30 years ago. A few countries pursued the ideal. But, says Dr Chan: “The approach was almost immediately misunderstood.”

Primary health care was misconstrued as poor care for poor people. It was also seen as having an exclusive focus on first-level care. Some dismissed it as utopian and others thought it a threat to the medical establishment. In the World Health Report, WHO proposes that countries make health system and health development decisions guided by four broad, interlinked policy directions. These four represent core primary health care principles. Universal coverage: For fair and efficient systems, all people must have access to health care according to need and regardless of ability to pay. If they do not have access, health inequities produce decades of differences in life expectancies not only between countries but within countries. These inequities raise risks, especially of disease outbreaks, for all. Providing coverage to all is a

financial challenge, but most systems now rely on out-of-pocket payments which is the least fair and effective method. WHO recommends financial pooling and pre-payment, such as insurance schemes. Brazil began working towards universal coverage in 1988 and now reaches 70% of its population.

People-centered services: Health systems can be reoriented to better respond to people’s needs through delivery points embedded in communities. The Islamic Republic of Iran’s 17,000 “health houses” each serve about 1500 people and are responsible for a sharp drop in mortality over the last two decades, with life expectancy increasing to 71 years in 2006 from 63 years in 1990. New Zealand’s Primary Health Care Strategy, launched in 2001, has as part of its core strategy an emphasis on prevention and management of chronic diseases. Cuba’s “polyclinics” have helped give Cubans one of the longest life expectancies (78 years) of any developing country in the world. Brazil’s Family Health Programme provides quality care to families in their homes, at clinics and in hospitals.

Healthy Public Policies: Biology alone does not explain many gaps in longevity, such as the 27-year difference in Glasgow’s rich and poor neighborhoods. In fact, much of what impacts health broadly lies outside the influence of the health sector. Ministries of trade, environment, education and others all have their impact on health, and yet little attention is generally paid to decisions in these ministries that have health impacts. WHO believes they should all be part of deliberations and that a “health in all policies” approach needs to be integrated broadly throughout governments. This will require a shift in political calculations since some of the greatest health impacts can be achieved through early childhood development programmes and education of women, but those benefits are unlikely to be seen during a single politician’s term or terms in office.

Leadership: Existing health systems will not naturally gravitate towards more fair, efficient (those that work better) and effective (those that achieve their goals) models. So, rather than command and control, leadership has to negotiate and steer. All components of society – including those not traditionally involved in health – have to be engaged, including civil society, the private sector, communities and the business sector. Health leaders need to ensure that vulnerable groups have a platform to express their needs and that these pleas are heeded. There is enormous potential to be tapped. In half of the world’s countries, health issues are the greatest personal concern for a third of the population. Wise leadership requires knowledge of what works. Yet health systems research is an area that is often severely under funded. In the United States of America, for example, health systems research claims only 0.1% of the nation’s health budget expenditure. Yet research is needed to generate the best evidence as a basis for health decision. By aiming at these four primary health care goals, national health systems can become more coherent, more efficient, more fair and vastly more effective.

Progress is possible, in all countries. Now, more than ever, there are opportunities to start changing health systems towards primary health care in all countries. The challenges are different for countries with different income levels, but there are commonalities. There is more money being spent on health than ever before and more knowledge to address global health challenges, including better medical technology. There is also now recognition that threats and opportunities in health are shared across the world. Aid is important for some countries, but the vast majority of health spending comes from domestic sources. Even today, in Africa, 70% of all resources for health come from domestic funds. Thus most countries have the ability to start moving towards and enjoying the benefits of primary health
The Use of Community Health Centers In Countries with National Health Insurance: Evidence from the Literature

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Abstract

Objectives: To explore the use of directly financed, publicly supported community health clinics in countries with national health insurance.

Methods: A literature search for studies of community health center services in nations with national health insurance.

Results: Most countries with national health insurance make use of community health clinics organized and staffed in a manner similar to the U.S. community health centers program in order to achieve population health goals, correct problems related to the maldistribution of health resources, and ensure that isolated populations receive care.

Conclusions: Health centers remain a basic element of the health system even in countries with national health insurance. While they cannot substitute for insurance coverage publicly supported health centers should be viewed as part of any overall national health policy.
Introduction

The original policy architects of the Medicare and Medicaid programs understood that even with expanded health coverage, large numbers of individuals living in medically underserved communities would continue to face significant barriers to healthcare. To address these concerns, the Johnson Administration in 1965 launched a demonstration program to establish Community Health Centers (CHCs) in urban and rural communities with significant health care underservice. The purpose of the program was to bring both newly-insured low income people and those who remained uninsured into the health care system, educating patients on how to gain access to and utilize care (Hawkins et al, 1997). The program was also viewed as a means for addressing the range of medical and health problems associated with deep impoverishment and isolation. Officials anticipated that by providing care in strategic locations with extended office hours, and by offering patient support services such as transportation and translation, health centers would improve access to care and health outcomes.

Following its initial successes, documented in numerous studies of health center impact and effectiveness, the program was codified in law in 1975 as part of the Public Health Service Act. By 2000, the program operated clinical sites in more than 3,000 urban and rural medically underserved communities. Federal appropriations for FY 2001 stand at $1.169 billion, and health centers currently serve over 12 million patients, 40 percent of whom are completely uninsured and virtually all of whom have low family incomes.
The high number of uninsured Americans (in 1999 the number of uninsured stood at more than 42 million persons) (U.S. Census Bureau, 2000) makes the need for a program such as health centers relatively obvious, particularly in a highly competitive health care climate in which financial pressures have had a documented impact on the availability of uncompensated and charitable care (Institute of Medicine [IOM], 2000). At the same time, a question that has been posed with some frequency in a variety of policy settings is whether programs such as health centers and other safety net providers (such as public health agencies and clinics) would be necessary for insured populations, particularly under a universal health insurance scheme in which the types of differentials in access that are associated with a separate public insurance program such as Medicaid are minimized. While this question may seem somewhat academic in the current environment, it is a significant one that merits consideration. Were the prevailing judgment to be that universal coverage would obviate the need for health centers and similar programs, then a powerful argument could be made that even the limited incremental federal health insurance reforms for children and families enacted over the past decade\(^1\) would have substantially reduced the need for increased direct operating subsidies for publicly assisted health care providers, on the assumption that individuals who gain coverage would move into private sector care settings, leaving those providers with additional capacity within current budget levels to care for the remaining uninsured.\(^2\) Indeed, this critical tension can be seen in modern literature on the subject of health centers and other safety net providers (IOM, 2000).

\(^1\)Kaiser Family Foundation, 1999.
\(^2\) Of course, this assumption at least implicitly reflects a belief that the new coverage would be permanent and thus would support a permanent alteration of health care utilization patterns. In fact, however, studies of coverage under Medicaid and its companion, the State Children’s Health Insurance Program, suggest that coverage tends to be episodic and unstable with lapses in eligibility resulting from problems in program administration and even slight changes in family income (See, e.g., Kaiser Commission, 2000).
To better understand the role of health centers and similar programs in an environment of expanded coverage, the National Association of Community Health Centers, in collaboration with the George Washington University School of Public Health and Health Services, undertook a review of the literature during the spring and summer of 2000 that was designed to examine the role of health centers in countries with national health insurance systems. The results of this literature review suggest that even countries with advanced health insurance schemes continue to provide direct and ongoing support for clinical health services in high need communities, as a component of their overall national health policies. Most countries with national health insurance maintain programs of directly supported community clinical service providers that appear to deal with the same types of needs and system limitations as those addressed by publicly assisted clinics in the U.S. The continued existence of such a clinical scheme is an indication of the inevitable limits of market power under even the broadest national health insurance scheme. The literature also suggests that even full national health insurance appears to have a lesser impact for certain patients and communities and that the use of a primary health delivery system that is tailored to addressing these issues can help close remaining health status and access gaps that transcend the financial and organizational impact of even the broadest national health insurance scheme.

This paper presents findings from our literature review and concludes with an assessment of the major policy issues that would arise in the reconfiguration of the U.S. health centers program were public policy makers to pursue significant health insurance expansions.

Methods
An extensive review of the literature on health centers in countries with national health insurance was undertaken. Results yielded a series of relevant documents, predominantly published under the auspices of the World Health Organization (WHO).

The WHO defines community health centers as frontline institutions that engage in the identification of community health needs, and the provision of medical care and prevention activities (WHO, 1994). The WHO has organized conferences and forums to discuss the role of health centers in different countries and has created Study Groups to examine experiences of different health center systems and make policy recommendations related to the needs of nations (WHO Forum, 1998; WHO, 1994). The WHO also has published literature on the role of health centers in urban areas and in district health care systems (WHO, 1997; WHO, 1992).

Community health centers are generally discussed in the literature irrespective of whether or not they operate in countries with or without national health insurance. To that end we identified 11 nations whose economies resemble those of the U.S. and that, according to studies of national health insurance, maintain universal, or near-universal, coverage systems. We then reviewed the literature on the extent to which these countries maintain programs of health centers for which they provide direct operating support.

Findings

Limited reference to the use of community health centers in both South Korea and South Africa was also found in the literature; however, these countries were omitted from this review because of differences in those nations' health systems or general economies.
Use of health centers by countries with national health insurance

Table 1 displays findings regarding the use of health centers in countries with national health insurance that were selected for review. Among the 11 countries that were identified as candidate nations, 9 appear to concurrently maintain health center-style programs of direct service delivery supported with direct revenue allocations as well as other sources of income.

Community health services and community medicine have a particularly long history in the United Kingdom. The historic so-called Peckham experiment, conducted in the UK at the Pioneer Health Center between 1935 and 1950, produced findings on health care access and positive health outcomes that, while decades old, remain part of the policy framework for health care in that nation (Pepper, 1998).

### Use of Health Centers in Countries with National Health Insurance

<table>
<thead>
<tr>
<th>Country</th>
<th>Evidence of Direct Support for Health Centers</th>
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<tbody>
<tr>
<td>United Kingdom</td>
<td>Yes</td>
</tr>
<tr>
<td>Canada</td>
<td>Yes</td>
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<tr>
<td>Spain</td>
<td>Yes</td>
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<tr>
<td>Australia</td>
<td>Yes</td>
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<tr>
<td>New Zealand</td>
<td>Yes</td>
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<tr>
<td>Sweden</td>
<td>Yes</td>
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<tr>
<td>Finland</td>
<td>Yes</td>
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We could find no evidence in the literature that either France or Germany maintained a formal program of community health centers as a matter of national health policy. However, at least one analysis has identified the lack of such a program as a factor underlying the nation’s inability to adequately address the health needs of populations, such as refugees, that may be marginalized by the general health care system. (Gardemann et al, 1998).

In Scandinavian countries, although health care services are very evenly distributed, health centers are viewed as efficient ways to provide primary care for a variety of reasons, including geographic accessibility and a more holistic approach to primary care (Hansagi, 1993; Marklund, 1989). In England, health centers provide the central means by which a community defines its own health needs, considers how those needs can be met and decides collectively on priorities of action (McNaught, 1991). In Finland, health centers are principally responsible for the organization of local primary, secondary, and tertiary healthcare services (Vehvilainen, 1999). In Canada, following that nation's health care reform, community health centers were given lead responsibility for home care, postoperative care, post-hospital follow-up and other tasks, and are credited with carrying out all of the vaccination campaigns and 90% of home care today (Blair, 1999). In Spain, the competence of health center professionals and their impact on health outcomes were recently identified as among their strongest points, giving the public care model an

<table>
<thead>
<tr>
<th>Country</th>
<th>Status</th>
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<tbody>
<tr>
<td>Switzerland</td>
<td>Yes (limited)</td>
</tr>
<tr>
<td>Japan</td>
<td>Yes</td>
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<tr>
<td>France</td>
<td>No</td>
</tr>
<tr>
<td>Germany</td>
<td>No</td>
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advantage over the private one (Rodriguez PMA et al, 1999). In Australia, health centers are more likely than private physicians to report involvement in group health promotion activity and broader community development initiatives (Baum et al, 1998). In New Zealand, researchers have found that taking health care into communities both enhances the wellness of the population and positively enhances the experience of place for local residents (Kearns, 1991).

**Strategic use of health center programs**

The literature indicates that even in countries with national health insurance schemes, community health centers are viewed as one of the most important health agencies to work with populations such as the urban poor, the homeless, the disabled, alcoholics, and drug addicts. In some countries, such as Australia and Canada, health centers also play an important role in the provision of family planning and maternal and child health care (Broom, 1997; Blair, 1999).

Countries with national health insurance tend to have a well developed and widespread network of health centers that are part of community (frequently referred to as district) health systems (WHO, 1997; McNaught, 1991; Vehvilainen, 1990). This is consistent with the trend toward decentralization within many national health systems (Kahssay, 1998; WHO, 1997). Because they shape their services on a community-wide rather than individual patient basis, health centers are viewed as more efficient in the administration of health promotion and disease prevention activities (Rodriguez PMA et al, 1999; Baum et al, 1998; Ejlertsson et al, 1985).
Several studies suggest that community health centers are typically designed to serve targeted populations that have unique and special health needs, such as the homeless, the disabled, the elderly, the mentally ill, persons with substance abuse-related health problems and other individuals whom health professionals in private practice either may resist serving or be not sufficiently experienced in the care of particularly high health risk populations to serve adequately (Power et al, 1999; Lanz et al, 1996; WHO, 1992; McNaught, 1991; Snowdon, 1987). Indeed, the literature suggests that it is both accepted and customary for private physicians to formally refer certain classes of patients to health centers (Blair, 1999).

The literature also suggests that health centers are used to provide access to basic health care to populations that are not considered citizens of the specific country they reside in, and thus are ineligible for the health insurance schemes made available to the rest of the population (WHO, 1992). In addition, several studies indicate that health centers play an important role in health systems for culturally distinct population sub-groups, such as aboriginal populations, whose health care traditions differ from the rest of the country and whose health needs and preferences require specific customization of medical care (Kent, 1999; Mackenzie, 1999; Wakerman et al, 1998; Kearns, 1991).

Specific organizational and functional dimensions of health centers

The literature indicates that, as in the U.S., health centers tend to be structured in certain distinct ways. In some countries health center staff function on a medical team basis in order to make services more comprehensive and responsive to community-wide issues rather than simply
the needs of individual patients (Blair, 1999; Kahssay, 1998; WHO, 1997). Emphasis is placed on integrated medical records in order to promote continuity of care and as a means of supporting multidisciplinary teams (Rodriguez PMA et al, 1999; Ejlersson et al, 1985).

The literature also suggests that a specific purpose of health centers is to link health care with social services and to provide a single location for the provision of a broad range of interventions that transcend traditional medical care and that reach into the worlds of nutrition, social services, educational services, recreation, and other interventions that promote overall health rather than simply diagnosing and treating disease (Kahssay, 1998; WHO, 1997; McNaught, 1991). Studies indicate that health centers can take on a social function as a place where people meet and that they promote dialogue on community health issues that cut across multiple sectors (Pepper, 1998; Campbell Forester, 1998; Lennie et al, 1990).

Studies suggest that increasing community involvement in decision making around health and health care is a specific aspect of the work of health centers in other countries. Health centers are used to generate participation by all segments of a community in public policy questions related to the nature and structure of the health system. In addition, health centers in some other countries play an important role in promoting access among underserved populations to emerging health care research that otherwise might elude populations whose status and health needs might be perceived as placing them beyond the reach of emerging therapies. For example, in South Africa, mobile health teams are directly linked to academic health centers and district decision-makers, while in Sweden, nearly one-third of all health centers participate in ongoing research. 
projects in the fields of epidemiology, preventive medicine and health services research (Tolman, 1998; Haglund, 1985).

**Challenges facing Health Centers**

Notwithstanding the acceptance of community health centers in countries with national health insurance schemes, health centers throughout the world share similar difficulties. The most important one appears to be a constant lack of financial resources (Blair, 1999; Kahssay, 1998; WHO, 1997). This funding shortage shows up in two respects. First, studies suggest that, as is the case in the U.S., the number of health centers is inadequate to meet the basic needs for which health centers are used.

Second, in view of the expanded health needs of health center patients, centers frequently report that their current funding levels are inadequate to provide the level of services (both medical and health and health-related) that their patients require, even in a national health insurance environment. This is particularly true in the case of those patients whose status may disqualify them from eligibility under the country’s national health scheme (e.g., immigrant populations).

A third issue facing health centers is retention of staff. As is the case in the U.S., health centers in many countries see the poorest and sickest patients. As a result staff frequently feel

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4 One study that used medical underservice formulas to calculate the number of health centers in the U.S. in relation to need found that at the funding levels in place at the time, health centers were able to serve only 15 percent of all persons in the U.S. at risk for medical underservice (Hawkins et al, 1993). Since that time funding levels have increased, but in real dollar terms, current health center grant funding levels stand at the same point at which the program was funded 20 years ago (Rosenbaum et al, 2000)
overworked and subject to high levels of stress. Moreover, the demanding nature of the care and relatively low pay makes retention of physicians and other clinical professionals difficult (Blair, 1999; WHO, 1997; Aoyama, 1996).

A fourth problem that is evident in the literature -- and again, one that is not uncommon in the U.S. -- is the limited understanding among the general public (and often among policy makers) of the role of community health centers in the health system, and inadequate cooperation from local and central governments. The literature suggests that health officials view this lack of political support at the community level as one of the significant causes of the under-financing of health centers (Blair, 1999; WHO, 1997).

**Implications and Conclusion**

In the U.S., where the number of uninsured persons remains extremely high, health centers are widely viewed as an efficient means of underwriting the cost of basic health care for an uninsured population. Although there is extensive literature on health centers' impact on health care access and health outcomes among lower income and vulnerable populations generally, the primary focus of American policy makers is on the role of health centers as a form of health care financing support for the uninsured. Consequently, less attention has been given to their impact on health care access and quality, which, in a context of health services research, is a separate matter.
As a result of this emphasis on the financial underwriting role of health centers, a somewhat strange dynamic has developed in public policy debates in the U.S. On the one hand, proponents of national health insurance frequently tend to perceive programs such as public clinics and hospitals as undermining, rather than enhancing a national health reform effort because as a source of financial support for the uninsured, they may diminish policy makers’ perceptions of the importance of a national health scheme. Ironically, those who work at or advocate for health centers or similar entities in the U.S. have historically been among the strongest proponents for insurance coverage expansions. Persons who see the struggle to secure adequate health care for uninsured persons are, if anything, particularly aware of the inability of modest grant-based funding to make more than the most limited incursions into financial barriers, particularly with respect to inpatient and specialty care, which are utterly beyond the financial capabilities of even the largest health centers. For proponents of health centers, improved health insurance remains a primary, not a secondary, U.S. policy goal.

At the other end of the spectrum in the national health policy debate are representatives of some (but by no means all) organizations representing private practitioners and health care institutions, as well as advocates of market remedies to social problems. These two groups, for different but related reasons, perceive health centers as no longer necessary in a world of expanded health coverage. Both groups tend to see health insurance as a complete correction for diminished access, because their analysis of the problem identifies financial barriers as the sole impediment to care. In addition, of course, professional societies with a natural interest in the economic opportunities of health care, do not want to lose insured business to competitors whenever they can avoid it.
Furthermore, certain health professionals view continued support for health centers and similar entities as a professional issue, since the existence of this alternative approach to the organization and delivery of medical care can be understood as an admission of the weaknesses of mainstream medicine in the case of populations whose health status, place of residence, cultural identity, and other attributes, place them outside the norm as defined by organized medical societies. The history of the U.S. health centers program is replete with examples from the field of organized professional opposition to health centers. Moreover, the literature on the existence of these programs in countries with national health insurance constitutes a powerful reminder of the fact that these problems do not disappear under national health insurance. They are the product of the human frailties that produce exclusionary and discriminatory attitudes and conduct and are not a function of money alone. One need look no further than the history of racial segregation in health care in the U.S., as well as a multitude of studies of racial disparities in health care within insured populations in the modern health system, to understand why insurance alone is not the cure.

The studies identified in this literature review underscore the ongoing need for health centers and similar programs, not as diversions from but as a means of enhancing and securing the promises of, a national health insurance scheme. To be sure, the expansion of insurance raises significant budgetary and practical issues for the operation of health centers that would merit resolution. Do higher levels of third party coverage diminish the need for direct operational subsidies for the uninsured? Should these funds remain for reinvestment in uninsured services or investment in additional communities with inadequate sources of care? How does the role of
publicly supported health care providers change in the context of expanded insurance coverage? Can these providers take on additional responsibilities that enhance access and health status and that would have been impossible in the absence of improved coverage (for example, closer collaboration with health professionals in private practice settings)? These are all legitimate and necessary questions that would arise in the context of insurance expansion. Yet none of them suggests that there is no need for health centers and similar providers – only an evolving role in a changing health system.

Producing a well functioning and more importantly, perhaps, a just health system goes beyond the extension of insurance coverage. The development and operation of primary health clinics – even high quality programs – can never substitute for comprehensive coverage and should not be put forth as a substitute. At the same time, the studies examined in this synthesis underscore the continued role of publicly supported programs, even in nations with universal health coverage, an indication of the fact that health care financing alone is a critical, but not the only, determinant of health care access.
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[3] CURRENT INTERNATIONAL ENGAGEMENTS:

There are many different types of opportunities when working abroad. They can be very short term or involve medium to long term contracts. They can range from urgent responses to humanitarian emergencies to planned appointments advising on health service development or on specific programs. They can even involve into long-term commitments of setting up “look-alike” health centers abroad.

NACHC has identified a number of health centers working abroad, though this list of health centers is likely incomplete. At the time of this publication at least 13 health centers are currently working abroad, and many more have expressed interest in becoming involved in some type of international work. The 13 centers currently operating abroad are working with at least ten different countries including: Cape Verde, Cuba, the Dominican Republic, Honduras, Hungary, Israel, Jamaica, Mexico, Swaziland, and Ukraine.

The global activities of these health centers include 1) providing resources, 2) global exchanges of training/technical assistance and information, and 3) creating sustainable health centers in other countries. These three categories are fluid and may not be complete. Some health center leaders are involved in all of these categories while some are focusing on just one. Every center’s experience is different but many of the gains are the same. Within these categories of activities is an essential common element – partnerships. Several health centers have begun working globally with foreign governments and communities, NGOs, academic partners, and other health clinics (see “Section 5: Partnership Building Internationally”, for more details on potential partnerships).

Included in This Section:

- 3.1 –Current List of Health Centers Working Abroad
- 3.2 –Activities of Health Centers Currently Working Abroad
- 3.3 –WHO Primary Care in Action: Country Profiles
Current List of Health Centers Working Abroad
(Last Updated August 2009)

1. **Alan Goldsmith, CEO**
   Jewish Renaissance Medical Center
   Perth Amboy, NJ
   Country of focus: Cuba, Hungary, Israel, Ukraine, Dominican Republic, and Jamaica
   International Work: Participating in several medical missions. Goldsmith is also a Goodwill Ambassador for the United Nations.

2. **Anne Nolon, CEO**
   Hudson River Health Care
   Tundra Valley, NY
   Country of Focus: Mexico
   International Work: Partnering with a health department in Oaxaca, Mexico.

3. **Ed Hendrikson, Director of Environmental Health**
   Salud Family Health Center
   Estes Park, CO
   Country of Focus: Mexico, Central America, and Swaziland
   International Work: Partnering with the Secretaria and the University of Guanajuato, Mexico. Hendrickson is also a UN ambassador.

4. **Maria Montanaro, CEO**
   Thundemist Health Center
   West Warric, RI
   Country of focus: Honduras
   International Work: Partnering with Shoulder to Shoulder

5. **Doug Smith, CEO**
   Greene County Health Care
   Walstonburg, NC
   Country of focus: Iraq
   International Work: Host site for visiting Iraqi professionals.

6. **Harry Foster, CEO**
   Family HealthCare Network
   Porterville, CA
   Country of focus: Central America, South America, and Southeast Asia
   International Work: They have been working very closely with the populations they serve in their home countries. Foster is also the board chair for the NCFH.

7. **Neal R. Gorman, Director of Public Relations**
   Lutheran HealthCare
   Brooklyn, NY
   Country of focus: Honduras
   International Work: Arranging medical missions and resources allocation.

8. **Paula Gomez, CEO**
   Brownsville Community Health Clinic
   Brownsville, TX
   Country of focus: Mexico
   International Work: Partnering with the government of Mexico

9. **Tim Comeaux, Assistant Director of Social Services**
   Brockton Neighborhood Health Center
   Brockton, MA
   Country of focus: Cape Verde and Haiti
   International Work: Coordinating medical missions, government partnerships, and recourse allocation.

10. **Leto Quarles, Clinical Medical Director**
    Clinica Campesina Family Health Services - Thornton Clinic
    Layfayette, CO
    Country of focus: Mexico
    International Work: Building Connections with medical students at the University of Colima, and creating partnerships with a clinic in Colima
Activities of Health Centers Currently Working Abroad... *a few examples*

- **Improving the Health of Farmworkers**

  **MEXICO**

  - A number of health centers have been working to establish international working relationships with other nations that yield high numbers of migrant farmworkers. Health centers have specifically been working with the Mexican government since 1962 to create bi-national projects that involve sharing culturally competent educational resources, staff exchanges, and collaborating with clinics in Mexico.

  - Currently working in Oaxaca, Mexico, one health center has truly redefined the geographic limits of farmworker outreach by working directly with the Mexican Federal government and several Mexican state health departments. The health center has partnered with a health department in Oaxaca, Mexico in response to the discovery of a large underground migrant population in its service area originating from Oaxaca. The health center signed an agreement with the Oaxacan Secretary of Health to collaborate in any way possible.

- **Sharing the US Community Health Center Model**

  **HONDURAS**

  - A Rhode Island health center has partnered with Shoulder to Shoulder and their sister organization, Hombro a Hombro, to address the health issues and social needs of isolated communities in poor regions of Honduras. In just over six years, the partnership has successfully set up a health center in Honduras caring for over 20,000 patients a year. The health center is organized and directed much like U.S. health centers. Over the years this partnership with the Honduras community has grown to include a community center, mental health services, and special outreach sites addressing the specific needs of the surrounding community.

  **IRAQ**

  - A health center in North Carolina hosted a delegation of 15 Iraqi physicians and midwives in the fall of 2008. They taught them about that Health Center Program and how best to serve high-risk populations.
### Reaching out to Similar Populations to form Partnerships

**CAPE VERDE**

- Another health center began working in Cape Verde in the spring of 2008. Staff members from the health center volunteered to go to Cape Verde to exchange information, meet with doctors and government officials to discuss the AIDS epidemic, and establish connections with local health clinics. The President of Cape Verde, Pedro Pires, has in turn visited the health center in the U.S. and formal partnerships are being established. This health center has a particularly large Cape Verdean population, so all community members are excited.

**MEXICO**

- One health center with a high Mexican patient population is working with a nearby university’s Center for Global Health in establishing a relationship with medical students at the University of Colima in Mexico. The intention of the health center is to collaborate with the medical students at the University of Colima in helping to educate them in best practices for community health. Eventually, the health center is hoping to establish a residency exchange where U.S residents would be able to spend a rotation at a health center in Colima, while Mexican medical students spend a rotation at the health center in the U.S.

### Connecting with Foreign Government Partners Across the Globe

**GLOBAL**

- A New Jersey health center created a foundation to support their global missions. Their providers are participating in medical missions all over the globe, not just in developing countries. The missions are based on invitations by foreign governments. Additionally, the founder of the foundation has been named the Goodwill Ambassador for the United Nations Economic and Social Council (UNESCO).

**MEXICO**

- A health center in Colorado has partnered with the University of Colorado and Baylor University to recommend a shared U.S. and Mexico policy on migrant workers, specifically on HIV/AIDS and tuberculosis. The Director of Environmental Health at this health center serves as the North American Delegate to the UNAIDS Programme.
Primary Health Care in Action: World Health Organization’s Country Profiles

The country profiles in this section are taken from the WHO’s 2008 World Health Report: Primary Care in Action. Each country profile provides information on the state of primary health care in that country. These country profiles can be used to better understand current international engagements relating to primary care, and to help begin the process of thinking about where your health center might go, should it decide to do work abroad.

Countries Profiled include:
- Bangladesh
- Fiji
- France
- Madagascar
- Oman
- Portugal
- Thailand
- The Islamic Republic of Iran

“This series of articles highlights the diverse country experiences – some positive, some less positive – of primary health care. Some country experiences pre-date the Declaration of Alma-Ata 1978, such as France’s country doctors and Cuba’s neighbourhood clinics. Some, such as Fiji and Madagascar, took their inspiration from the Declaration. Others have revitalized their primary health care approach, for example New Zealand, with positive results. The series comprises abridged versions of articles published in the Bulletin of the World Health Organization in 2008 and texts derived from the World Health Report 2008. Figures for gross national product (GNP) per capita are provided in international dollars ($), a hypothetical currency that has been developed to enable meaningful comparison between countries. An international dollar has the same purchasing power as the US dollar has in the United States of America.”


Bangladesh centre brings health care to rural area

The Gonoshasthya Kendra in Bangladesh has made great progress over the past four decades in breaking the cycle of poverty and poor health through its network of affordable rural health-care units.

The centre’s clinics and hospitals provide health care in 13 rural districts north-west of the capital, Dhaka, to 1.2 million people. In Bangladesh, one of the world’s poorest countries, about half of the population lives below the national poverty line.

Gonoshasthya (meaning ‘health for the people’) Kendra (meaning ‘centre’ in Bengali) really lives up to its name. It runs a health insurance scheme and families pay a premium according to their ability to pay. The centre also runs supporting projects, including a medical college, agricultural cooperatives, community schools and a generic drug-manufacturing plant.

Project serves several districts

Although Bangladesh signed the Declaration of Alma-Ata in 1978, which called for the implementation of a primary health care approach as the key to achieving ‘health for all’, little has been done to make this approach a significant part of the national health care policy, says Gonoshasthya’s founder Dr Zafrullah Chowdhury.

While government-run hospitals offer low-cost medical care, they are often inaccessible, crowded, understaffed and lacking medicines, he says. “In Bangladesh there are 4000 [government-run] family and health-care centres,” he says, “but they are empty most of the time. The doctors come for three to four hours a day; a health centre should run 24 hours a day.”

But at the Gonoshasthya’s hospital in Savar, patients are treated by female health workers. The women receive six months’ basic training, which includes learning how to take and test blood, taking urine and stool samples, inserting intravenous lines and diagnosing some diseases.

Female health workers overcame doubts

Some elders and other villagers frowned on the idea of women talking about family planning and offering vaccinations. But in time people accepted that women could fulfil these roles too, says Beauty Rani De, who heads the health workers’ training programme.

Through its community-based approach, she says the centre has contributed to the success of several national public health campaigns, including the provision of oral rehydration salts to treat diarrhoeal diseases, family planning and immunization.

Bangladesh in numbers

- Life expectancy (both sexes, 2006): 63 years
- Gross National Product per capita (PPP in international $, 2006): 1230
- Per capita total expenditure on health (PPP in international $, 2005): 57
- Number of physicians (per 10 000 population, 2005): 3

This is an abridged version of an article published in the Bulletin of the World Health Organization in February 2008.


Fiji’s drive towards primary health care stalled

The Fijian village of Natogadravu is a showcase for the well-being primary health care can bring with strong leadership and when the community gets fully involved.

“The number of people dying has decreased and not too many people are sick now compared to the olden days,” says Nacanieli Sosenabarar, who has witnessed many changes in the village, 30 kilometres from Fiji’s capital, Suva.

Now in his 60s, he no longer lives in a bamboo hut, but a modern house made of iron and concrete. He no longer draws his drinking-water from the potentially polluted nearby river; these days it comes from a tap in his house, which also has a water-seal flush toilet.

High hopes for primary health care

These improvements in basic amenities, which have helped to improve the health of villagers, stem from the enthusiasm with which the village embraced primary health care as the means for achieving ‘health for all’ back in the late 1970s, after Fiji signed up to the 1978 Declaration of Alma-Ata.

Fiji sought to overcome its lack of resources by galvanizing communities to improve health across its 100 or so islands that are today inhabited by 844 048 people.

“We have experienced the benefits of primary health care and it is important that every village in Fiji take primary health care very seriously,” Sosenabarar says. “We have had the benefits because we have a very effective village committee that always works together with the people in the village to decide on every development.”

But in many other parts of Fiji, the results have been less impressive. Promising early developments lost momentum in many villages. Many initiatives stalled in the 1980s.

Inadequate resources

Dr Jona Senilagakali, who was the country’s Permanent Secretary for Health at the time of Alma-Ata, blames this stagnation on, among other things: poor government policy and a lack of central government support to the villages, inadequate resources and monitoring from central government; and a brain drain that has resulted in a shortage of doctors and nurses.

“I think 70–80% of the population has access to health services but only 40% has access to quality health services. There is no proper monitoring of the health standards in the communities or villages,” agrees Dr Josaia Samuela, Fiji’s National Adviser on Family Health.

He says it is the government’s responsibility to act. “The government has to adjust now in order to deliver good health to the people to a required standard … What is the use of having a vision of health for all without providing adequate resources?”


Fiji in numbers

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This is an abridged version of an article published in the Bulletin of the World Health Organization in March 2008.
**France** Primary Health Care in Action

**French rural doctors offer the personal touch**

Since the time of King Louis XIV (1638-1715), the country doctor has been an integral part of French rural life, attending to the basic health needs of villagers.

Country doctors offer the personal, one-to-one care that hospitals and specialist clinics cannot. Empathy, trust and an intimate knowledge of individual case histories – these are their stock in trade.

While the country-doctor tradition goes back centuries in France, addressing people’s individual health needs – treating the whole person, rather than the disease – is a core part of the primary health care approach. Treating the patient as a whole person means going beyond a narrow clinical diagnosis to find the answer to the patient’s health problems. That can involve discussions of diet and other lifestyle issues or health advice on, for example, screening for cancer and regular health checks.

“In medicine, there is on one side, the technology, and on the other, the relation with the patient. For me, it is a 50/50 distribution … A patient that trusts his doctor and keeps a positive attitude will heal better,” says Dr René Nicolas, the local doctor in the village of Genouillac in the central French department of Limousin.

**Threat to country doctor**

Several developments, however, threaten to erode the role of the country doctor – a key one being the difficulty of recruiting young doctors for rural areas due to perceived harder working conditions. In central and south–western France, in particular, hundreds of practices closed between 1996–2001 when the local doctor retired.

Genouillac is a case in point. Five of the seven doctors practising in the region are over 50, including Nicolas himself. Indeed, the ageing of rural doctors is part of a larger challenge for policy-makers, that of providing health care for an ageing population. Much of Nicolas’s daily work involves treating the elderly.

For Dr Guenael Rodier, a French doctor who is a programme director at the World Health Organization (WHO) in Geneva, the work of the country doctor is in danger of being diminished by a fear of litigation and by changed patient expectations. “They want the best services, so they all want to go to Paris or other bigger cities, where they can access larger hospitals,” says Rodier.

**Adjusting to changes**

This supposed diminishing role must be placed in the context of a relatively strong French health system overall. In a report published in 2000, the WHO ranked France’s health care system as one of the best in the world.

In 2006, average life expectancy for women in France was 84 years (one of the highest in the world) and 77 years for men; and the system is constituted to ensure equitable geographical coverage and efficient interaction between the different sectors (i.e. public and private hospitals, private practitioners, medical auxiliaries, the pharmaceutical industry).

Nicolas is more positive in his appraisal of the country doctor system. The system continues to work well, he says, and is facing the challenges cited by Rodier by adjusting to modern changes while maintaining the personalized service that has served patients so well for centuries.

Nicolas welcomes the advent of advanced scientific treatments but does not feel threatened by their presence. “Before, country doctors felt impotent at times, but things have improved,” he says.

This is an abridged version of an article published in the Bulletin of the World Health Organization in October 2008.

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**France in numbers**

- Life expectancy (both sexes, 2006): 81 years
- Gross National Product per capita (PPP in international $, 2006): 32 240
- Per capita total expenditure on health (PPP in international $, 2005): 3406
- Number of physicians (per 10 000 population, 2005): 34
Madagascar primary health drive achieves mixed results
When the first batch of 1500 young health aides was dispatched in 1980 to Madagascar’s villages, it was thought to herald a new era in health care for the island nation off the southeast coast of Africa.

The project was the centrepiece of the country’s primary health care programme, launched in 1978 with high hopes of meeting the Alma-Ata goal of providing health for all by 2000.

The “health for all” idea was not to eradicate every disease, but to attain an acceptable level of health, equitably distributed throughout the world. The results in Madagascar, however, have been mixed, with strong advances in some areas and little progress in others.

On the plus side, islanders today have never been more motivated to look after their health, says Professor Dieudonné Randrianarimanana, cabinet director of the Madagascar Ministry of Health, Family Planning and Social Protection.

Health has improved
Currently, average life expectancy is 59 years which represents an increase of about 6 years from its 1990 level. Poliomyelitis has been eradicated. Officials there say the prevalence of leprosy is less than 1 per 10 000; and infant mortality is decreasing (in 2006 the probability of dying in the first year of life was down to 72 deaths per 1000 live births compared with 84 in 2000 and 103 in 1990).

But 30 years on, only 60–70% of the population has ready access to primary health care services, officials say. Many people still have to walk 10 kilometres or more to receive treatment, though mobile health centres have been introduced in remote and sparsely populated areas.

Like Randrianarimanana, nurse Florentine Odette Razanandrianina has experienced the ups and downs of primary health care. She arrived in the village of Ambohimiarintsoa, 200 kilometres from the capital Antananarivo, in October 2006 to run the health clinic.

She provides twice-weekly prenatal and postnatal check-ups. She also offers child immunization and vaccination, family planning services and disease treatment.

But five of the centre’s seven small rooms are in a poor state of repair and lack sufficient equipment, Razanandrianina says. “We have five mattresses for only one bed. Consequently, we are often obliged to let patients sleep on the mattresses placed directly on the soil.”

Health workers receive mixed reception
There are many other health centres in a similarly poor state of disrepair across Madagascar, officials admit.

Also, frictions can arise when modern practices are perceived as counter to traditional customs. Since moving to the village, Razanandrianina’s efforts to teach people about the need for personal hygiene have not always been welcome.

Despite these setbacks, Razanandrianina has not curtailed her efforts. For example, when people from villages further away have chosen not to attend vaccination clinics, she has gone to them.

“The every time we visit the remotest villages, people wait for us in a group. They really appreciate our visits,” Razanandrianina says.

This is an abridged version of an article published in the Bulletin of the World Health Organization in June 2008.

Madagascar in numbers
Life expectancy (both sexes, 2006): 59 years
Gross National Product per capita (PPP in international $, 2006): 870
Per capita total expenditure on health (PPP in international $, 2005): 33
Number of physicians (per 10 000 population, 2005): 3

Oman creates successful health system

In the late 1970s, the Sultanate of Oman had only a handful of health professionals. Many people had to travel up to four days just to reach a hospital, where hundreds of patients would already be waiting in line to see one of the country’s few doctors, most of whom were expatriates.

All this changed in less than a generation, thanks to political commitment to health and oil revenues. Oman has invested consistently in a national health service and sustained that investment over time. There is now a network of 180 local, district and regional health facilities staffed by over 5000 health workers providing health care to the vast majority of Oman’s 2.2 million citizens, with coverage now being extended to foreign residents.

Over 98% of births in Oman are attended by trained personnel and over 98% of infants are fully immunized. Life expectancy at birth, which was less than 60 years towards the end of the 1970s, now is about 74 years. The under-five mortality rate has dropped by a staggering 94%.

Current five-year plan

The primary health care system is based on the wilayat, or district, the unit of local administration that is the closest to the community. The central role of community health work to a primary health care approach was placed firmly on the international health agenda by World Health Organization Member States in the Declaration of Alma-Ata in 1978.

Under the five-year health plan for 2006–10, the Sultanate’s goal is to ensure that 100% of the population are served by health centres and mobile health teams. By that time, the goal is to have 90% Arabic-speaking staff, including doctors and nurses. All primary health centres are to be equipped with basic laboratory and maternity services.

The goal is also to refine the hospital referral system through clear delineation of catchment areas, while medical records are to be digitalized in 75% of primary health centres to facilitate continued care.

Oman’s primary health care successes are featured in the World Health Report 2008: Primary Health Care – Now more than ever.

Oman in numbers

- Life expectancy (both sexes, 2006): 74 years
- Gross National Product per capita (PPP in international $, 2005): 19 740
- Per capita total expenditure on health (PPP in international $, 2005): 390
- Number of physicians (per 10 000 population, 2005): 17

Portugal amongst world’s most successful in reducing mortality

Life expectancy at birth is now 9.2 years more than it was 30 years ago, thanks to one of the world’s most consistently successful performances in reducing mortality.

Since the mid-1970s, infant mortality rates have halved every eight years to reach three per 1000 in 2006, on a par with levels in the rest of western Europe, and down from over 40 in 1975.

Portugal’s success is the result of the development of a nationwide primary health care system, rooted in the principles of the Declaration of Alma-Ata in 1978 when World Health Organization Member States pledged to provide health for all based on primary health care.

Political pressure
Portugal recognized the right to health in its 1976 constitution, approved two years after a democratic revolution ended over 40 years of authoritarian rule.

Political pressure to reduce the large health disparities led to the creation of a national health system, funded by taxation and complemented by public and private insurance schemes and out-of-pocket payments.

The constitution describes the system as universal (for everyone), comprehensive (full-range of services) and free of charge.

A network of health centres staffed by family physicians and nurses progressively covered the entire country. Portugal considers this network to be its greatest success in terms of improved access to care and health gains.

Some imbalances
Nevertheless, some imbalances have emerged over the years, between hospital and primary care, for example, and between the numbers of nurses and physicians.

As patients are still making intensive use of hospital emergency departments, the 2004-2010 National Health Plan aims to further decentralize primary care facilities. In this way, primary care — the first point of contact with the country’s health services — will be brought closer to the people through smaller scale family health units.

Portugal’s primary health care successes are featured in the World Health Report 2008: Primary Health Care - Now more than ever.

Portugal in numbers
Life expectancy (both sexes, 2006): 79 years
Gross National Product per capita (PPP in international $, 2006): 19 960
Per capita total expenditure on health (PPP in international $, 2005): 2034
Number of physicians (per 10 000 population, 2005): 34

Volunteers vital for Thailand's health successes
“Last year I still had to sit in a wheelchair when going out. But look at me now,” says 57-year-old Suparat Chanakit as she practises Tai Chi in the grounds of the Wat Kae Nok Buddhist temple in central Thailand.

“I feel much better and stronger when coming here to exercise and meditate,” adds Chanakit, who had been using a wheelchair due to a heart condition and a problem with her legs.

Wat Kae Nok is among hundreds of Buddhist temples participating in Thailand’s Health Promotion Temple project, initiated in 2003 by the Public Health Ministry as part of the Healthy Thailand agenda.

Health promotion is key
Thailand’s primary health care programmes—in which health promotion and disease prevention are key—have had considerable success over the past three decades, with mortality in children aged under five dropping from around 75 such deaths per 1000 in 1975 to 8 in 2006.

Medical advances cannot take all of the credit for this success. Much of it is due to the efforts of community health volunteers working among Thailand’s 64 million people, health officials say. Buddhist monks and temples, for example, have been strongly involved in health promotion and education, working hard to prevent people getting sick in the first place, particularly in remote, rural communities.

These activities may range from educating women on how to feed their infants to advising people about healthy life-styles and nutrition.

There are more than 800,000 health volunteers across the country. They have played a crucial role in controlling many communicable diseases. They were, for example, instrumental in the dramatic decline of protein-calorie malnutrition in preschool children.

Health care rooted in communities
The central role for community work was placed firmly on the international health agenda by the World Health Organization and its Member States in the Declaration of Alma-Ata in 1978. The goal these countries set themselves was to achieve universal health care, or ‘health for all’ by means of a primary health care approach by the year 2000.

The ‘health for all’ idea was not to eradicate every disease, but to attain an acceptable level of health, equitably distributed throughout the world.

For Dr Amorn Nondasuta, who heads the country primary health care programme: “Although we cannot achieve all the goals of the health for all declaration, we have been successful in our strategy of creating health volunteers,” he says. “As a result, the primary health care system today is deeply rooted in local communities.”

Thailand in numbers
- Life expectancy (both sexes, 2006): 72 years
- Gross National Product per capita (PPP in international $, 2006): 7440
- Per capita total expenditure on health (PPP in international $, 2005): 323
- Number of physicians (per 10,000 population, 2000): 4

This is an abridged version of an article published in the Bulletin of the World Health Organization in January 2008.
Iranians open the door to health for all

They have been described as an “incredible masterpiece”. The Iranian health houses, introduced amidst the 1980–1988 war with Iraq have extended basic health services to the poorest, most far-flung corners of the Islamic Republic of Iran.

Despite initial opposition from experts who thought the scheme’s infrastructure was too ambitious and that the health workers lacked training, thanks to the scheme over 90% of the Islamic Republic of Iran’s 23 million rural population now has access to health services, officials say.

“At the beginning, we could never imagine such a breakthrough. We were at war and the country was in a miserable condition,” says Dr Sirous Pileroudi, a former senior official with the Ministry of Health and one of the founders of the Iranian health-care system.

Community workers are key

Community health workers have made a significant contribution to the sharp decline in mortality rates in the past three decades, helping to reduce deaths among infants and pregnant women, and curbing contagious diseases, according to Health Minister Dr Kamran Baqeri Lankarani. In just two decades, the country has seen an eight-year increase in life expectancy (now 71) since 1990.

Health workers or behvarzan from the Farsi words beh (good) and varz (skill) are trained to meet the basic health-care needs of people living in rural areas. Community health workers are often from the village they serve.

There are about 17,000 of these rural medical posts, the most basic unit of the Iranian health system. On average, each health house serves 1500 people and just over half the 30,000 community health workers are women.

When needed, the health houses refer patients to rural health centres, which are responsible for emergency case management, supporting the health houses, and supervising both the health technicians and the behvarzan or community health workers.

Community health work is part of a primary health care approach. This approach was the strategy countries adopted in the Declaration of Alma-Ata in 1978 to achieve the goal of ‘health for all’ of their people by 2000.

Shift to chronic diseases

“People enjoy primary health care services free of charge,” says Dr Mohammad Esmael Motlaq, the director of the Centre for Healthcare Promotion. “The health workers are well familiar with the culture and traditions and that is a big advantage.”

Dr Kamel Shadpour, another of the Iranian health-care pioneers, says the health houses did well when the main issue was to contain contagious diseases. They are doing the same now with chronic diseases like diabetes and hypertension.

This is an abridged version of an article published in the Bulletin of the World Health Organization in August 2008.

The Islamic Republic of Iran in numbers

- Life expectancy (both sexes, 2006): 71 years
- Gross National Product per capita (PPP in international $, 2006): 9800
- Per capita total expenditure on health (PPP in international $, 2005): 677
- Number of physicians (per 10,000 population, 2005): 9
GETTING STARTED:

Making the initial decision to have your health center participate in various types of international work is a big first step. However, the process between making the decision to participate in work abroad and the final product can at times seem confusing and overwhelming. This section of the toolkit is designed to make that process a little easier by providing information on the benefits of working internationally, a checklist of things to consider before “going global,” information on the various areas health centers are involved, suggestions on how to develop your approach, and advice for developing and sustaining skills for international work.

Furthermore, many health centers who have already been through the process of establishing programs internationally have contributed their advice and training materials to this section, as well as their encouragement of the many benefits of working internationally.

Included In This Section:

- 4.1 – Benefits of Working Internationally
- 4.2 – Is Your Health Center Ready to Go Global?
- 4.3 – Potential Areas of Involvement for Health Centers Looking to Work Internationally
- 4.4 – Developing Your Approach: Initial Considerations for Your Health Center
- 4.5 – Developing and Sustaining Skills for International Work
  - Level One
  - Level Two
  - Level Three
- 4.6 – Information on Medical Evacuation Insurance
Getting Started: Benefits of Working Internationally

Benefits of Working Internationally:

- **BENEFITS TO THE HEALTH CENTER:**

  Health centers engaged in these activities inform NACHC of the following value added to their U.S. centers:
  - Retention of current doctors and nurses;
  - A successful recruitment tool for new doctors and nurses. “International Healthcare” is trendy today among new doctors and having an international component to the clinic is a way to win new doctors over to primary care;
  - Enables health centers to better understand the populations they are serving;
  - Improves cultural competency among staff, including foreign language competence and cultural awareness;
  - Boosts morale (reduces “burn out”);
  - Provides staff with improved communication skills and adaptive techniques to better serve their patients;
  - Supports quality improvement activities, particularly around patient self management and processes of care;
  - Mitigates the effects of borders and patient migration as barriers to providing continuous care;
  - Develops new strategies to improve health care, treatment, and education for severely impoverished communities;
  - Establishes new contacts in key areas; and
  - Increased local, national, and international recognition of the role of U.S. health centers in minimizing health disparities.

- **PROFESSIONAL BENEFITS**

  Experiences gained overseas by health center staff contributes significantly towards their professional development and they return to their health center with enhanced clinical, organizational, and managerial skills which are of great benefit to their patients and profession. Overseas experience can be very valuable for rapid learning to:
  - Prioritize and allocate scarce resources
  - Plan, monitor, and audit
  - Develop project management skills and disciplines
  - Conduct health needs assessment for local populations
  - Integrate primary and secondary care
  - Manage change
  - Thinking on your feet and making things happen
  - Manage yourself, finances and organizations
  - Train, teach and develop human resources
  - Work in multidisciplinary teams and provide leadership
4.1 Getting Started: Benefits of Working Internationally

*PERSONAL BENEFITS:*

According to those who have worked in the field, NACHC has included the top ten personal benefits to working aboard.

1. Global awareness
2. Adaptability - coping with complexity and uncertainty
3. Interpersonal skills - team-working and collaboration
4. Handling responsibility, including leadership through communication and empowerment
5. Stress management through more balanced perspectives
6. Self-assurance
7. Problem solving including coping with adversity
8. Exchanging skills
9. Strategic thinking
10. Sense of humor

*These are critical skills for tackling the complexity of modernizing and transforming health services for the benefit of patients. They are also critical for personal career development.*

*ANECDOTAL BENEFITS:*

“It is immensely valuable for personal inspiration, motivation, and sense of perspective” Tim Comeaux, Assistant Director of Social Services, Brockton Neighborhood Health Center, Brockton, MA

“I’ve never met anyone who’s regretted working abroad. And it really does change your life”. Ed Henrikson, Director of Environmental Health, Salud Family Health Center, Estes Park, CO.

“We have doctors and nurses who are so invested in our Honduras program that they will not leave the clinic. Also, the international component to our clinic has helped us win young doctors over to primary care.” – Maria Montanaro, Thundermist Health Center, Woonsocket, RI

Managers and clinicians alike find their experience immensely challenging, and fulfilling. Many describe how they have re-discovered their original sense of vocation.

Aid agencies stress the personal resourcefulness that is needed to work in difficult circumstances, in remote locations and in unfamiliar cultures with little direct peer support.

“We provided training for Community Health Workers in Oaxaca and Puebla which raised the level of even this bi-lingual, culturally competent group” – Anne Nolon, CEO Hudson River Health Care,
Going Global: Things to Consider

A health center’s first priority is to provide affordable and accessible quality care to its patients and surrounding community. So although the benefits of international engagements can be great, it is first necessary to assess the capacity of the health center for such engagements. The health center must ensure adding an international component to its current operations will not jeopardize its current stability and future sustainability. Below are five essential competencies which help assess this capacity:

1: HEALTH CENTER MATURITY
   - Is the health center mature enough to take on additional operational, administrative, and financial responsibilities associated with starting up a project abroad, while maintaining a constant level of stability in its ability to provide timely, quality care to its patients at the home center? While adding an international project for a mature center might provide immense benefits, trying to extend the operations of a new health center prematurely might endanger the success of the health center’s current operations.

2: BOARD SUPPORT
   - Is the board of the health center supportive and in consensus about starting up an international engagement? It is important to involve in the decision process about whether or not to go global. The prognosis of success with an international project is much greater if the board is actively engaged from the beginning.

3: ACCESS TO PARTNER ORGANIZATIONS
   - Does the health center have access to quality, sustainable, and fiscally sounds partner organizations (such as academic medical programs) that could share the burden of cost and insure a stable supply of manpower to a new global project? Most health centers currently involved in international projects point to strong partnerships as a main reason for their success.

4: ABILITY TO HANDLE EMOTIONAL CHALLENGES
   - Are the administrators, coordinators, staff, and volunteers at the health center prepared to handle the emotional and physical challenges, as well as the responsibility that come with working within the context new cultures and extreme poverty? These challenges can be just as difficult as those associated with securing finances and other logistics.

5: LANGUAGE CAPABILITIES
   - Does the health center staff possess the language capacities necessary to sustain the proposed international engagement? Or, is the health center prepared to provide the tools necessary for their staff to increase their language capacity should it become necessary?
Potential Areas of Involvement for Health Centers Looking to Work Internationally

- **Providing Resources.** One activity is the donation of needed health care resources to underserved communities abroad. Some health centers are donating the most fundamental health care supplies, including medical equipment, computers, and clothes, to the regions in which they partner.

- **Global Exchanges.** Health centers are engaged in a variety of international “give and take” activities. On the give side is providing expertise. Some health centers provide training and technical assistance to international communities on program evaluations, needs assessments, means for disseminating health information, and health care planning in under resourced areas. Health centers have also sent providers on global health care delivery missions. Some health centers have hosted foreign clinical providers and country dignitaries to help train them on the specifics of the health center program. On the take side, health center leaders have visited other countries to learn more about how community approaches to care can function in any environment, and then translate these lessons learned locally. Additionally, many health centers have developed partnerships with NGOs, governments, academics, and health clinics to create an avenue to share and exchange best practices. Some health centers are even using this information exchange to track a number of their patients across borders.

- **Residency Exchange.** Some health centers are looking to establish residency exchanges between U.S. health center residents, and residents abroad. The intention is for the U.S. resident to be able to spend a rotation in a health center abroad, while the international resident spends a rotation at a U.S. health center. The opportunity allows for cultural and professional development for both individuals, presents opportunities to learn best practices in different cultural and resource settings, connects international residents abroad with similar patient populations in the U.S., and furthers both residents commitment to global health.

- **Building Health Centers Abroad.** At least two health centers have even established health clinics in other countries, though several others have expressed interest. These centers function much like their domestic sister centers. They are built on the community oriented primary care framework, provide comprehensive primary health care services, have at least a 51% consumer majority board, and provide care to all in need. This type of international work is intended to be a long term sustainable solution for a foreign community’s health care needs. The health centers abroad are staffed by full time providers from the country of residence, though U.S. centers often send their own staff for short periods of time.
Emergency Work: Globally, the World Health Organization has technical responsibility for all the health aspects of disaster reduction and humanitarian assistance. Its emergency and humanitarian department maintains an intelligence network for advanced planning of emergency responses. The WHO website (www.who.int/en/) contains an immense wealth of material on current crises, as well as providing access to public health resources, emergency management essentials and guides to other resources. The International Federation of the Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian organization, and plays a critical role in humanitarian emergencies.

Humanitarian emergencies typically require rapid mobilization of a workforce already skilled in dealing with these emergencies, and there is a growing recognition and emphasis on post-conflict recovery, often after the international media spotlight has moved. Initial international experience has typically been acquired by working on development projects.

Development Work: There are projects and placements in most developing countries, and there are a wide variety of non-governmental organizations (NGOs) and governments involved in this work. Health Exchange (http://healthexchangenews.com) is a good starting point and provides a comprehensive list of NGOs active in this field.
Developing Your Approach: Initial Considerations for Your Health Center

Once a health center believes it has the competencies necessary to work abroad in an international engagement, many questions will arise surrounding the logistics of the project’s impact on health center operations. Addressing some of these inevitable questions from the beginning makes the later stages of planning and implementation process much easier, and reduces the chances of running into a logistical roadblock. Below are some issues to consider:

- How might you recognize and communicate to health center employees the value of international work for professional development, improving workforce retention, and promoting working with diversity in a different setting?

- How can this recognition be turned into practical support for individuals? This should provide equity of opportunity for staff to benefit from the development afforded by international work.

- What will be the scope for implementing new, or reviewing existing career breaks for those staff members who spend time abroad as part of the international engagement?

- How will you separate the responsibility of operating the existing health center with the development of an international project?

- What are some ways to garner the full potential of new expertise acquired through international experiences, and how can the health center sustain and build upon that knowledge over time?

- Are there any NGO, government, or academic institutions currently working with the health center that might be interested in getting involved in the international project?
Would the health center be interested in involvement with wider town/city networking initiatives with other local partners with the same country of interest?

How can the health center’s international work allow the health center access to additional funding?

Would the health center be interested in building international links and contacts through hosting international visitors, and through other learning opportunities? Would the health center potentially invite international partners to the states (NACHC is also happy to meet with individuals to provide a national overview).

What types of learning and training opportunities to tackle particular skill/experience requirements would the health center need to supply?

How might the health center best help its coordinators, staff, and volunteers develop culturally sensitive medical practices for use once abroad?

What are the realistic start-up costs for the project? Who will be responsible for actively searching for grants? Be cognizant of hidden fees such as those for visas, work permits, lawyers, immunizations, etc.

How will the health center become familiar with the health policies and other national laws of the country and region in which it wants to work?

What is the target population and what are the reasons for choosing this particular population that the health center can provide to its home community?

What type of international engagement does the health center believe will best benefit the target population and the health center?

Will you need Medical Evacuation Insurance? (See Section 4.6)
Developing and Sustaining Skills for International Work:

This section provides some more details about different skill levels and how health centers may be able to classify staff when working on a project overseas.

Three levels of skill for international work can be distinguished:

1. Those who want professional development in international work and can contribute within a supervised structure

2. Those with some international experience who can make a significant contribution

3. Those with significant international experience who can function as senior consultants

Note: Language skills can be useful and important at all levels, and can affect possible locations and the kinds of opportunities that will be available.

Level One: (Those who want professional development in international work and can contribute within a supervised structure)

Example: A person who was working abroad for the first time either as a doctor, nurse, resident, or health professional. They are learning the ropes but have proven to be capable of their current event.

Requirements clearly vary depending on the type of work your health center is doing, but step one will typically require the following:

- Initial professional qualification and registration
- A commitment to the aims of the project
- Personal resourcefulness
- Team work skills
- Cultural sensitivity
- Languages
- Commitment to transferring skills
Level Two: (Those with some international experience who can make a significant contribution)

Example: This is a licensed and trained medical provider or other specific professional with a specific expertise. This person has worked abroad before and may even have some familiarity with the local language or culture.

For these postings agencies value:

- The track record of previous international expertise
- Country specific expertise
- Specific clinical expertise
- Some management expertise

Level Three: (Those with significant international experience who can function as senior consultants)

Example: These are individuals who work abroad at least once every other year. They are capable and efficient in leading a team and understand the politics and culture of the country. They typically have a solid foundation in the local language.

For these postings agencies value

- Substantial international experience and expertise is a pre-requisite, and program management expertise would normally be expected.
Information on Medical Evacuation Insurance

What It Is:

Medical Evacuation Insurance guarantees coverage should an employee need to be evacuated from a location for medical purposes. This includes air transports which can cost anywhere between $25,000 to over $100,000 depending on the location and type of evacuation. Although the need for medical evacuation insurance will depend on the specific type of international engagement of the health center, several health centers currently working abroad incorporate the cost of medical evacuation insurance into their operational expenses for their international projects.

How it Works:

Few insurance providers directly provide medical evacuations. Rather, normally the insurance company subcontracts companies that focus on medical evacuations. Once arrangements for coverage for medical evacuations have been secured, a call-collect number will be issued to be used should the need arise to discuss and or coordinate a medical evacuation. In all cases, insurance companies will not pay for medical evacuations that are not coordinated through and by the insurance company. In the event of an emergency where it is suspected a medical evacuation might be necessary, the injured party or a representative will contact the insurance company via the call-collect number. The insurance company will often seek council from their medical doctors, and those at the scene of the incident to see if a medical evacuation is warranted for the patient. If a medical evacuation is deemed necessary, the insurance company will send in a plane or helicopter, and often time medical personnel to evacuate the injured individual. Each plan may work slightly differently, so it is important to know exactly what your plan would cover should you choose to purchase medical evacuation insurance. Also, medical evacuations have different price tags depending on where the evacuation takes place. It is therefore important to base the amount of coverage you chose on the location of your staff.

For More Information:

Contact your existing insurance company to learn about their policy concerning medical evacuations, or check the State Department’s website concerning medical insurance for travelers abroad (http://travel.state.gov/travel/cis_pa_tw/cis/cis_1470.html) for suggestions about the type and amount of medical evacuation insurance to be purchased.
PARTNERSHIP BUILDING INTERNATIONALLY:  

Many health centers involved in successful international engagements point to a strong and sustaining partnership as a key element of their success. Establishing a three-way partnership between the health center, a partner program, and the organization abroad helps to more evenly distribute organizational responsibilities, manpower, and financial resources. By sharing the burdens associated with international engagements, projects have a more favorable chance of success over a sustained period of time and a less likely risk of burnout.

Although there are several organizations working internationally, an ideal partner is one that is financially stable, has a sustainable source of manpower, is structurally sound, and is able and willing to provide the balance of freedom and support the health center desires. Often times these partners are universities or academic programs, Non-Governmental Organizations (NGOs) and International Non-Governmental Organizations (INGOs), or government partners. However, health centers have also forged relationships with partners who might not fit into one of the previously mentioned categories.

This section of the toolkit offers suggestions of possible contacts as you go through the process of forging lasting partnerships.

Included In this Section

- 5:1 – University and Academic Partnerships
- 5:2 – NGO/INGO Partnerships
- 5:3 – Government Partnerships
- 5:4 – Other Types of Partnerships
University and Academic Partnerships:

Many health centers working abroad have found partnering with medical schools with International Residency Programs in Family Medicine, or other international offerings for its students and residents to be a key component to their success. Partnering with an academic institution provides both parties with much desired resources. While the partnership gives the health center the necessary manpower to sustain international projects, the academic institution gain several benefits in their ability to provide their students with international medical experience. Below you will find a list of US Medical Schools that have formalized International Residency Programs or international opportunities for its Medical Students and Medical Residents.

Medical Schools with Formal International Residency Programs:

*(Source: [www.amsa.org.global/ih./resprograms.cfm](http://www.amsa.org.global/ih./resprograms.cfm))*

- Baylor College of Medicine (Houston, TX)
- Brown University (Providence, RI)
- Case Western Reserve: University Hospitals Family Practice (Cleveland, OH)
- Duke University (Durham, NC)
- Indiana University (Indianapolis, IN)
- Marshall University School of Medicine (Huntington, WV)
- Medical College of Wisconsin (Milwaukee, WI)
- University of Cincinnati (Cincinnati, OH)
- University of Hawaii (Mililani, HL)
- University of Massachusetts (Worcester, MA)
- University of Minnesota (St. Paul, MN)
- University of Nebraska Medical Center (Omaha, NE)
- University of Pittsburgh (Pittsburgh, PA)
West Virginia University Byrd Health Sciences Center (Morgantown, WV)

Yale Internal Medicine/Primary Care Medicine (New Haven, CT)

Medical Schools with International Opportunities:
(Source: Foundation for Advancement of International Medical Education and Research: www.iome.faimer.org)

Albert Einstein College of Medicine of Yeshiva University

Alpert Medical School, Brown University

Boston University School of Medicine

Brody School of Medicine at East Carolina University

Columbia University College of Physicians and Surgeons

Creighton University School of Medicine

Duke University School of Medicine

East Tennessee State University James H. Quillen College of Medicine

Emory University School of Medicine

Florida State University College of Medicine

Howard University College of Medicine

Indiana University School of Medicine

Jefferson Medical College of Thomas Jefferson University

Joan & Sanford I. Weill Medical College of Cornell University

Johns Hopkins University School of Medicine

Loma Linda University School of Medicine
Loyola University of Chicago Stritch School of Medicine
Medical College of Georgia
Meharry Medical College
Mercer University School of Medicine
Michigan State University College of Human Medicine
Morehouse School of Medicine
Mount Sinai School of Medicine of New York University
Northwestern University Feinberg School of Medicine
Ohio State University College of Medicine
Oregon Health and Science University
Pennsylvania State University College of Medicine
Sanford School of Medicine of the University of South Dakota
Southern Illinois University School of Medicine
Stanford University School of Medicine
Stony Brook University School of Medicine
SUNY Downstate Medical Center College of Medicine
Temple University School of Medicine
Texas Tech University Health Sciences Center School of Medicine
Tulane University School of Medicine
Uniformed Services University of the Health Sciences
University at Buffalo, SUNY School of Medicine & Biomedical Sciences
University of Alabama at Birmingham School of Medicine
University of Arizona College of Medicine
University of Arkansas College of Medicine
University of Chicago, Pritzker School of Medicine
University of Connecticut School of Medicine
University of Florida College of Medicine
University of Hawaii John A. Burns School of Medicine
University of Illinois College of Medicine at Peoria
University of Illinois College of Medicine at Rockford
University of Illinois College of Medicine at Urbana
University of Iowa Carver College of Medicine
University of Kansas School of Medicine
University of Kentucky College of Medicine
University of Louisville School of Medicine
University of Michigan Medical School
University of Nebraska College of Medicine
University of New Mexico School of Medicine
University of North Carolina at Chapel Hill School of Medicine
University of North Dakota School of Medicine & Health Sciences
University of Puerto Rico School of Medicine
University of Rochester School of Medicine and Dentistry
University of South Carolina School of Medicine
University of Tennessee College of Medicine
University of Texas at Dallas Southwestern Medical School

University of Texas Health Science Center at Houston

University of Texas Health Science Center at San Antonio - Pediatrics

University of Texas Medical Branch at Galveston

University of Utah School of Medicine

University of Vermont College of Medicine

University of Virginia School of Medicine

Vanderbilt University School of Medicine

Virginia Commonwealth University School of Medicine

Wake Forest University School of Medicine

Washington University in St. Louis School of Medicine

Wayne State University School of Medicine

West Virginia University, R. C. Byrd Health Sciences Center

Yale University School of Medicine
NGO/INGO Partnerships:

Creating successful NGO/INGO Partnerships can help assure the feasibility and sustainability of an international engagement. Some organizations might be interested in direct involvement, while others may at least be able to provide resources or information to health centers new to international work. Below is a short list of NGOs and INGOs for health centers to consider:

American Public Health Association
http://www.apha.org/

American Academy of Pediatrics
http://www.aap.org/

American Red Cross
http://www.redcross.org/

Center for Global Development (CGD)
http://www.cgdev.org

Center of Excellence in Disaster Management and Humanitarian Assistance
http://coe-dmha.org/

Cross-Cultural Solutions
http://www.crossculturalsolutions.org/

Doctors of the World Home Page
http://www.dowusa.org/

Direct Relief International
http://www.directrelief.org/

East Africa Medical Assistance Foundation
http://www.eastafricafoundation.org/

Freedom from Hunger
http://www.freedomfromhunger.org/

Friends of the Global Flight
http://www.theglobalflight.org

GAVI Alliance
http://www.gavialliance.org

Global Assistance
http://www.globalassistance.org/

Global Health Council
http://globalhealth.org

Global Health Education Consortium
http://www.globalhealthedu.org

Infectious Diseases Society of America (IDSA)
http://www.idsociety.org

International Committee of the Red Cross (ICRC)
http://www.icrc.org/

The International Development Research Centre
http://www.idrc.ca/en/ev-1-201-1-DO_TOPIC.html

Panos
http://panos.org

Pathfinder
http://pathfinder.org/site/PageServer

PedsCCM: International Child Health
http://pedscrm.org/ICHealth.php

Treatement Action Group (TAG)
http://www.aidsinfonyc.org/tag

Mennonite Central Committee
http://www.mcc.org/

Medicines for Malaria Venture (MMV)
http://www.mmv.org

Nelson Mandela's Foundation
http://www.nmcf.co.za/index.php

Project Concern International
http://www.projectconcern.org/site/PageServer

Refugees International
http://www.refugeesinternational.org/

Volunteers in Technical Assistance
http://www.vita.org
Government Partnerships:

Establishing relationships with U.S Agencies and other Intergovernmental Organizations can be useful as they can offer a plethora of resources due to their size and scope. They can be a source of funding or be able to provide information on finding grants. They also may be able to provide valuable information on the area of interest and the already present organizations doing similar work. Below is a list of some US Agencies and Intergovernmental Organizations to consider:

Centers for Disease Control and Prevention (CDC)  
http://www.cdc.org

Global Fund to Fight AIDS, Tuberculosis and Malaria  
http://www.theglobalfund.org

John E. Fogarty International Center  
http://www.fic.nih.gov

National Institute of Allergy and Infectious Disease (NIAID)  
http://www.niaid.nih.gov

National Institute of Child Health and Human Development (NICHD)  
http://www.nichd.nih.gov

National Institutes of Health (NIH)  
http://nih.gov

UNAIDS, the Joint United Nations Programme on HIV/AIDS  
http://www.unaids.org

United Nations Volunteers  
http://unv.org

United Nations Children’s Fund  
http://www.unicef.org

United States Agency for International Development (USAID)  
http://usaid.gov

World Health Organization (WHO)  
http://www.who.org

World Bank Development Sources  
http://www.wds.worldbank.org
Other Types of Partnerships:

Although Academic Institutions, NGO/INGO and Government organizations are common types of partnerships, they are not the only groups worth considering when building partnerships internationally. Below you will find a list of Direct Care Service organizations, Community-Based organizations, and Foundations to use as a resource for building strong and sustainable international partnerships.

Direct Care Service Organizations:

- CARE
  [http://www.care.org](http://www.care.org)
- Carter Center
  [http://www.cartercenter.org](http://www.cartercenter.org)
- Doctors without Borders/ Médecins Sans Frontières
  [http://msf.org](http://msf.org)
- Family Health International (FHI)
  [http://www.fhi.org](http://www.fhi.org)
- International Trachoma Initiative
  [http://www.trachoma.org](http://www.trachoma.org)
- Partners in Health
  [http://pih.org](http://pih.org)
- PATH
  [http://www.path.org](http://www.path.org)

Community-Based:

- African Christian Relief
  [http://www.christianrelief.org/africa-programs.html](http://www.christianrelief.org/africa-programs.html)
- Catholic Medical Mission Board (CMMB)
  [http://www.cmmmb.org](http://www.cmmmb.org)

Foundations:

- HandsNet
  [http://handsnet.org](http://handsnet.org)
- National Center for Farmworker Health
- The St. Vincent Pallotti Center
  [http://www.pallotticenter.org](http://www.pallotticenter.org)
- Bill and Melinda Gates Foundation
  [http://www.gatesfoundation.org](http://www.gatesfoundation.org)
- Clinton Foundation
  [http://www.clintonfoundation.org](http://www.clintonfoundation.org)
- Elizabeth Glaser Pediatric AIDS Foundation
  [http://www.pedaids.org](http://www.pedaids.org)
- The Foundation Center (for help finding other funders)
  [http://foundationcenter.org](http://foundationcenter.org)

Note: The Foundation Center has library/learning centers in New York, Atlanta; Cleveland; San Francisco; and Washington, DC; as well as other several cooperating collections that offer free access to information resources. On their website you can find free access to search tools, tutorials, downloadable reports, and other grant databases. There is also a more detailed database they offer which can be accessed by an online subscription for a fee.

- Kaiser Family Foundation
  [http://www.kff.org](http://www.kff.org)
- Rockefeller Foundation
  [http://www.rockfound.org](http://www.rockfound.org)
[6] USEFUL TRAINING MATERIALS AND ARTICLE SUMMARIES:

As you move forward in planning for your international project, there will inevitably be questions that your health center will have to confront. Ethical questions might arise, such as, who is going to benefit most from your work abroad, the health center or the people receiving the health care? Or, how do you make sure your work has significant and sustainable value for the target population? Further questions of logistics might also surface concerning how you can introduce global health into your current residency program in a way that meets residency requirements, while also providing desired incentives for doctors interested in international work to pursue primary care.

Included in this section you will find training materials and article summaries that will help you find answers to some of these questions, along with an example of a “Team Leader’s Handbook” used by one family medicine residency program to help prepare their residents for an international medical mission.

This section was put together with the input of several health centers who are currently working abroad. We would like to thank them for graciously offering their materials for other health centers to use while developing their international projects.

Included in This Section:

- **6.1 – International Medical Brigades: Who Benefits Most- Local Populations or Foreign Participants?**
  By: Edward Zuaweste, MD; and Candace Kuge CRNP, CNM

- **6.2 – Introducing Global Health in to CHC Residency Training Programs**
  Information from “Going Global: Considerations for Introducing Global Health into Family Medicine Training Programs” by Jessica Evert, MD; Andrew Bazemore, MD, MPH; Allen Hixon, MD; and Kelley Withy, MD, PhD. (Full article located in the appendix)

- **6.3 – Channeling Medical Volunteerism Toward Sustainable Health Change**
  From the “Shoulder to Shoulder: Model developed by Jeffery E. Heck, MD; Andrew Bazemore, MD, MPH; and Phil Diller, MD, PhD (Full article located in the appendix)

- **6.4 – Example of a Team Leader’s Handbook Table of Contents**
  Handbook used and developed by “Shoulder to Shoulder”. (Full Handbook located in the appendix)
International Medical Brigades –Who Benefits Most: Local Populations or Foreign Participants?

Edward Zuoweste MD; and Candace Kuge CRNP, CNM

Introduction:

Every year several thousand volunteer medical professionals and support staff travel abroad to participate in a variety of “medical brigades”. Millions of dollars are spent on transportation, food, lodging, medications, and medical equipment during these traditionally rather brief trips to all of the developing countries of the world. Many of us over the years, have questioned whether this type of activity has immediate and long term value to the medically underserved individuals that the brigades have targeted to help. This brief paper is a small attempt to address these questions and is based on the published literature on the subject and a great deal of persona experience of the authors (a family physician) and a nurse (a nurse practitioner and nurse midwife) after several years of work in Mexico, Honduras and Guatemala.

What Constitutes a Good/Effective Medical Brigade?

- Sustainability –Return to the same location frequently over a long period of time

- Cultural Sensitivity and Competence

- There must be local provider and leadership buy-in. They must provide the direction and priorities of the project.

- There must be an emphasis on sustainable preventative health activities and programs

- The program must be broad-based (water purification, sanitation, education, nutrition, housing and socioeconomic activities)

- Ultimate goal should be to improve long term access to quality care that should then translate into improved health outcomes and improved quality of life.

- Must build a sustainable local infrastructure collaborating with local public health system.

- Should have ongoing, consistent evaluation of local health outcomes to demonstrate success or failure of health intervention strategies

- Must demonstrate efficient use of resources (local and imported – human and material)
Useful Training Materials and Article Summaries:

**International Medical Brigades: Who Benefits Most?**

- Utilization and education of local health care providers—both traditional and non-traditional.

- Extensive local/regional/national needs assessment with long and short term strategic plans for improvement

- Identify “root causes” of disease and poor outcome data

- Go Slow!! With small steps measuring the sustainable improvement of outcomes and adjusting course when appropriate in a timely manner

- Should always strive to place Quality over Quantity

- Must address/solve problems with the most impact on overall health first (latrines before X-ray machines)

- All participants should display a caring/non-judgmental attitude in all activities

- Always charge something for services (local control of collection and use of funds generated). This adds value to the services provided and maintains pride in the individuals who have received the services.

- Any donated equipment must have a plan for repair and replacement

- All projects should be designed locally because different situations tend to have significant variations on the individuals served and problems they encounter

- Remember that providing comfort to individuals (emotional and physical) has great value

- Knowledge gained by the participants on the brigade is important and can have a life changing effect that is often hard to measure

- Remember that social structural issues of injustice or inequality may be critical factors determining health and poverty.

- The Ultimate Goal is to recruit and train local providers and staff (traditional and non-traditional) so that all that is needed is financial support (salaries/medications/equipment) and continuing medical education.
What Constitutes a Poor/Non-Effective Medical Brigade?

- Religious or medical tourism
- Lack of pre-trip cultural competence training and education
- Poor use and selection of resources (medications and equipment)
- Inability or refusal to identify and utilize the local health care infrastructure both traditional and non-traditional
- Pure “Pill Dispensing Brigade” with emphasis on the number of patients seen, drugs dispensed, or procedures performed with no study of outcomes or long term improvement. Remember, it does no good to repair a child’s cleft lip only to have the same child die of malnutrition or diarrheal disease the following month
- Medical arrogance (“Our way is the best/only way”), treating local providers like students or orderlies, not asking for advice nor accepting it when offered
- Free handouts of food, medications and clothing are a very temporary fix that only instills dependence on a population and diminishes pride
- The “medical brigade: may be competition to the local providers who cannot survive giving expensive medications and treatment for free or at a very low cost
- Short-term missions may cosmetically mask deeper ills of social, political, and economic inequalities, thereby delaying or preventing long term solutions
- Short-term mission trips are extremely expensive to arrange and complete
- Short-term mission groups almost always do work that could be done (usually better) by individuals of the country they visit
- The millions of dollars spent each year to spend physicians, dentists, nurses and students to developing countries could cover the salaries of thousands of full-time un-employed physicians and nurses in those countries who need work and already embody the language and cultural competency to do so
**Examples to Consider:**

1. Eighteen US college students raised $25,000 to fly to Honduras for Spring Break. They painted an orphanage, cleaned the playground and played with the children for seven days. The students universally had a great time and loved it! The orphanage’s yearly budget is $45,000 which covers staff salaries, building maintenance, food, and clothing for the children. The staff of the orphanage was very grateful for the students visit and all of their help, however had a few important observations: “That one week use of $25,000 was over half our yearly budget –we could have done so much more with that money”. “We could have hired two Honduran painters who needed the work, hired four more teachers, build a new dormitory for the children, and bought a new set of clothes for all the children”.

**Questions to Consider:**

- The students could have just raised the money and gone to Cancun for Spring Break, and given nothing to the orphanage
- The students could have raised the money and just sent it of the orphanage –but then none of them would have any idea of the conditions of the orphanage, the children, or the culture of Honduras
- This trip may have been a “life altering experience” for some of these students with far reaching future dedication to work or financial support to developing country activities.
- The stories told by the returning students may have inspired future trips to the same orphanage or village and/or ongoing financial support for the orphanage
- Could there have been a better way to approach this “mission”? Collaborative planning with the leaders of the orphanage to determine their high priority areas of need? Maybe painting the orphanage was not high on their list, maybe the construction of a new dormitory had a much higher priority? Maybe the work could have been done with a combination of donated time by the students and salaries paid to local painters to work and/or paid supervision of the student’s activities?
- Pre and Post needs assessments and evaluation that could have included orphanage staff satisfaction survey. What did we do well? What could we have done better? Next time what would you like to see us help you accomplish for the orphanage?
2. Fifty-seven health care individuals traveled to Honduras from Baltimore, Maryland for a five day medical mission: 13 MDs (2 FPs, 3 Peds, 2 optho, 3 ob/gyn, 1 ped/ortho, 1 derm and 1 pod). Each spent $1,200 for the trip --$68,000 total plus a “container” of “medical items” valued at $400,000. The “team took over the local small hospital for five days” and performed several varied surgical procedures (using much of the equipment that they had brought in the container), and saw a large number of outpatients with a wide range of complaints. The dermatologist saw “400 patients in the 5 days”. In describing the experience one of the physicians stated that “we had hoped to do a lot of teaching of the local physicians but we had sustained contact with only one of the local physicians, we assumed that the other staff physicians were intimidated or threatened by our presence”. The one physician that was present and interested in learning from the team was described by the dermatologist as “a very poorly trained general practitioner who consistently misdiagnosed a variety of dermatological lesions not unlike my experience with many of the primary care physicians in the US. So I gave him a copy of my dermatology textbook in Spanish hoping that he might be able to learn something.”

Questions to Consider:

- Do you think that a pre-trip orientation took place with this group and if so how effective do you feel, was the training in cultural competency?

- How much value was realized from the $400,000 worth of equipment and medications that accompanied the group (Everything that was brought on the mission stayed in Honduras)?

- Why do you think that the local physicians were not “present and interested in learning”?

- What do you think that the local hospital physician did with the dermatology textbook that he was given?

- How could think this trip could have been better organized?

- Is there any value noted from this type of “medical mission trip”

- Is it surprising to note that the dermatologist on the trip wrote an article about the “mission” in a local medical journal expounding on all of the “wonderful humanitarian health care that was provided by this trip to Honduras” and concluded with the contact information for his private dermatology practice and the title and method of acquiring his textbook?
This author (EZ) and another attending leader of a trip to Honduras several years ago to a “new site”, decided to do “something special” for the community through their own personal finances. Both of these individuals had extensive experience with travel and international work. They decided to buy paint for the very “worn appearing” Centro de Salud (health center) of this rural poor community and have (did not really give them much of a choice) the medical students and residents on the trip paint the center on Saturday and Sunday. Being “culturally competent” they took both the center’s nurse and the president of the local health committee with them to El Salvador to pick out the color of paint that would be used. The following weekend without too many complaints all the participants on the brigade worked many hours to paint the entire health center both inside and out with the paint purchased by these two attendings. Everyone congratulated each other on a job well done and were extremely pleased by the greatly improved appearance of the health center. At the end of the brigade, an exit meeting was held with the leaders of the brigade and the health committee and other community leaders. The president of the health committee gave a very heart felt speech thanking all the brigade members for the excellent care that had been given to her community over the previous two weeks. When asked by the brigade leaders to describe what might have gone better during the brigade, the president replied in a very respectful but firm manner the following comment: “We really appreciate all of the work that went into the painting of our health center, and it is very beautiful. However, for the money that you spent on buying the paint and all of the work that went into the project, we, the committee could have described several other projects that are a much higher priority for our community. So in the future if you have funding that you would like to give to the community, maybe we could be included in the planning stages and participate in the decision of how to use the funds.” Both of the brigade leaders looked at each other in embarrassment realizing that they had broken one of the “cardinal rules” of good/effective medical brigades. Always, always involve the local leaders in any project that you plan to “help the community”, never, never assume that you know what the community needs or wants.

Questions to consider:

- Is it ever OK for an individual or group to use their “own money” to provide something to a community that they are working with, without input from the community?
- What did these two experienced attending physicians learn from this experience?
- Who should be included in the decision making in a community?
- What if there is not agreement on an issue or an issue is creating significant unrest or controversy in the community?
- What are the guidelines for “how much” should be given to or provided for a poor community without some sort of reciprocal “matching” donated time or resources from the receiving community?
General Questions for Further Thought:

1. Why are we participating in a medical brigade (individually or as a group)?
2. Why is this country so poor?
3. What problems does the local population face?
4. What has the United done to help or harm the country of interest?
5. What can I/we do to help (here and at home)
6. Are you teaching and learning from the local individuals you are in contact with during the trip?
7. When you get home will you support organizations working to fight injustice and poverty?
8. Are all of the activities you are involved with during this trip working toward long term solutions?

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Introducing Global Health into CHC Residency Training Programs:

Residents and medical students alike are showing a growing interest in working abroad as a result of increased evidence of the benefits of global health, including improved physical exam skills, increased resource consciousness when making diagnostic and treatment decisions, experience working with underserved populations, and increased interest in primary care. By capitalizing on this interest and incorporating global aspects into their residency and medical training programs, Community Health Centers can increase the attractiveness of primary care and achieve greater long term success at recruiting and retaining future doctors.

This section offers insight and things to consider as you begin to develop your program, suggested components of a global health training curriculum, and possible solutions to potential hurdles you might encounter while developing a program to introduce global health into your primary care training programs.

**THINGS TO CONSIDERATIONS:**

- **What are the goals of the proposed global health program?** Although the main goal is to provide residents training in the field of global health, there are often secondary goals for training programs such as delivering sustainable health services abroad, expanding the primary care model to other countries, and establishing longitudinal educational missions for residents to develop research and professional skills as part of a career mentoring program. Whatever the specific goals might be, it is necessary to develop the program design mindful and reflective of these goals.

- **Identify who the “champions” are and engage them from the beginning.** These champions might come from diverse backgrounds (for example, chairpersons, program directors, and individuals with experience in refugee health may all be “champions”), but together their skills and dedication can provide essential academic, logistical, and/or financial support during program development. Engaging these individuals and organizations from the beginning is a necessary component for health centers going global with their residency and medical training programs.

- **Identify what resources are available to permit global health training.** From the beginning of program development, assess the scope of the various resources you could use to develop and sustain your program. Looking towards academic centers, the local community, religious organizations, teachers, deans, and other individuals and institutions who are interested in global health and might be willing to help develop a training program is a start. It is also necessary to look for grantees, local and regional donors, and other entities with shared interests who might be willing to help fund the development of an international training site.

Information for this section consists of summaries and excerpts taken from “Going Global: Considerations for Introducing Global Health Into Family Medicine Training Programs” by Jessica Evert, MD; Andrew Bazemore, MD, MPH; Allen Hixon, MD, and Kelley Withy, MD, PhD. | For full article, see appendix
What type of global health training best fits the program and its resources? The types of resources available will help determine if the residency program will offer formal, longitudinal programs, or simply permit or help arrange elective rotations for its trainees. Programs may add didactic curricula focused on global health into their core didactics, offer off-site training in tropical medicine, or block global health classes. The most successful programs will use the available resources in conjunction with new ideas to go forward creatively, to ultimately create a sustainable program in global health training.

COMPONENTS OF A GLOBAL HEALTH TRAINING PROGRAM:

Didactics and Curriculum Development: Conferences, speakers, presentations, and other didactic components of the training program need to be catered towards preparing residents for international work. Residents might have varying degrees of global health knowledge and international experience and the didactic component of the program needs be designed with this in mind. Often times more graduated discussions are beneficial to introducing the topic of global health and international medicine to those who have little background on the subject. When looking for individuals who can teach on global health, it is sometimes helpful to look to the surrounding community for those outside the medicine department. Local schools of public health, other health professionals, experts in public policy and social sciences can be assets in helping to broaden the resident’s global health knowledge. However, while the “what” that is addressed by factual competencies demanded in global health education, exposure to career opportunities within the realm of global health work is also important in order for the resident to also gain an understanding of “how” global health works. See Table 1 in full article for Resources for Faculty and Curriculum Development in Global Health

Peer Education: Often times one of the best educational resources are the residents and medical students themselves. Take advantage of the skills the trainees might already possess such as prior global health experience, or previous international medicine practice and incorporate them into the formal didactic programs with student-led seminars and journal clubs. Faculty members can help facilitate these activities by formulating a list of relevant journal club topics and articles that can be annually updated. Peer education helps the trainees enhance their factual knowledge as they learn teamwork, networking, and problem solving skills necessary for a work in the global health arena.

Experiential Learning in the International Setting: Implicit in incorporating global health into a residency training program is medical or health training experience in an international setting. Programs for experiential learning internationally are varied in nature and are unique to the goals of the program. Some programs allow residents to participate in clinical rotations at their site, while others rely on the residents to organize the actual clinical rotations in its entirety. Other times residents will chose to participate in non-clinical global health opportunities. Community health centers with already established international programs can incorporate their residents and medical students into their programs abroad (as long as it is within the context of their curricular requirements). Other resources to help residents locate international opportunities are the International Health Opportunities Database maintained by the Global

**Experiential Learning in the Domestic Setting:** With increasing globalization, it has become easier to integrate global and domestic educational activities for trainees. This is especially true for residents at community health centers. Although resources in developing countries are usually significantly less than those available in the United States, the medically underserved populations community health centers serve domestically, encounter similar barriers as patients abroad such as low literacy rates, poor transportation, and limited financial resources. Helping residents see the correlation between domestic and international medically underserved populations can help to justify and fund global health activities.

**Preparation and Debriefing:** When designing a global health program in community health center residencies, it is necessary to take into consideration how you will prepare the residents and medical students for their actual work abroad. Their initial preparation levels will be varied, but preparation should be tailored accordingly. Debriefing should include a formal mechanism for program evaluation, as well as practical training such as how to keep the doctor healthy while abroad.

**Mentoring:** Providing strong mentorships for trainees is an essential part of any successful residency program. Ideally the mentors would have extensive training in global health. However, programs short on mentors with global health expertise should take advantage of existing global health networks in the community. Programs can also look to annual and regional organizations that host meetings on global health, schools of public health and/or international affairs, and local non-profit organizations to provide guidance to residents. See Table 2 in full article for lists some of these organizations.

**Research and Scholarly Activities:** Community based research is a good way for residents to learn about how to assess the needs of a population at the community level using limited resources, while gaining experience in understanding the effectiveness of various interventions at meeting those needs. Supervisors should be involved in the research process from the beginning to ensure feasibility of design given time and logistical constraints, and also that the research is of a beneficial nature to the community. Mentors should provide careful oversight throughout the entire process and provide guidance on research ethics and how to design research projects with proper participation that provide previously unavailable resources to the community.

**Program Evaluation:** In order for a residency program to be sustainable and continue to receive funding, an evaluation process must be a part of the program. How the evaluation measures success can vary depending on what outcomes are most indicative to explaining how well the main goals established in the beginning of the program were achieved. For example, program success might be measured by patient and staff satisfaction, increase in cultural competency levels, capacity building within host country or community, changes in specified outcomes, etc. Whatever the means for measuring success are, it is important to design an evaluation process.
from the outset and be consistent throughout the program’s duration in collecting data for the chosen indicators of the program’s success. Some health centers find issuing surveys before and after the program to be the easiest way to evaluate progress. Health centers with the resources to do so might choose to also track health indicators of the population served, and the progress of the trainees throughout the entire duration of the program.

HURDLES TO DEVELOPING GLOBAL HEALTH TRAINING PROGRAMS:

- Financing: Financing global health experiences for both the trainees and CHC staff is always a hurdle. However, there are a variety of resources to use when searching for these funds. Directors of the program will need to be familiar with their regional fiscal intermediary’s interpretation of the Center for Medicare and Medicaid Services rules on graduate medical education payments for residents on away electives. The ultimate goal is to provide global health on site training without jeopardizing the financial sustainability of the program. Working through an established preexisting nonprofit or governmental program is advisable for programs without institutional or private financial support. Below are a few possible places to begin looking for funding opportunities:
  - Private foundations or church organizations
  - The Foundation for the Advancement of Medical Education and Research
  - Mini-Fellowships are available through a Yale-Johnson & Johnson program
  - The Organ Health and Sciences University (see website for list of opportunities)
  - The World Health Organization
  - Industries with interests in the region trainees will be going
  - Department of Health and Human Services grants for residency training (for domestic or territorial activities)
  - International aid organizations
  - US National Institutes of Health John E. Fogarty International Center (see their Directory of International Grants and Fellowships in the Health Sciences)
  - National Institutes of Health (research grant opportunities)
  - Global Infectious Disease
  - The United States Agency for International Development (USAID) and Global Health Council (support grant mechanisms for improving health)
  - Country or continent-specific support

- Supervision: Most programs require resident supervision by a board-certified physician in primary care. The challenge is often finding supervisors who meet these credentials at the international site. Ideally, having an on-site faculty member can solve this problem. Alternatively, having a program or faculty member travel with the residents is another way to meet this requirement. If it is impossible to have a faculty member on site, or traveling with the residents, this requirement can sometimes be side-stepped by having residents focusing on research instead of clinical work. Partnerships with organizations that go on regular missions such as Doctors without Borders, is another way to bypass this complication should it arise.

Information for this section consists of summaries and excerpts taken from “Going Global: Considerations for Introducing Global Health Into Family Medicine Training Programs” by Jessica Evert, MD; Andrew Bazemore, MD, MPH; Allen Hixon, MD, and Kelley Withy, MD, PhD. | For full article, see appendix
Useful Training Materials and Article Summaries:
*Introducing Global Health into CHC Residency Training Programs*

- **Employment Law:** Residents may be contracted by hospitals, universities, or consortia. The employers (i.e., the health centers) must follow state laws regarding worker’s compensation and disability insurance. Some state programs will not cover overseas experiences, while at the same time it may be illegal for the program not to do so. Make sure to contact the lawyers for your health center, as well as the university or hospital legal council for help interpreting state-specific regulations early on in the program development process.

- **Liability:** On international projects, the question of whether or not to cover one’s trainees and faculty commonly arises. There is limited precedent for medical tort in most developing countries, although this is beginning to slowly change as a result of globalization. Before deciding about coverage for residents and medical students, health centers and program directors should consult their own institutional policy for malpractice coverage while abroad and the policies of their insurer university. It is also often helpful to contact global health peers in the country of interest to gather information on the specifics of malpractice law in that region. It is also important to consider the nature of the international project. Sometimes research electives do not require the same coverage as clinical rotations. Additionally, sometimes host countries will agree to provide liability waivers to volunteer medical workers, and some universities will build medical evacuation insurance into their student health insurance. (For more information specifically on medical evacuation insurance for health center faculty, please see section 4.6)

- **Sustainability:** Sustainability in global health work is often times neglected, and often times as a result residents learn an ineffective model of global health involvement. Many medical missions only provide short term solutions for acute problems, which goes against the principle of providing sustainable quality care embedded in the nature of health centers. To avoid this, the program should favor experiences that (1) integrate with local health systems to ensure follow-up care and (2) address the determinants of health more broadly, exposing learners to the principles of community-oriented primary care, public health, and sustainable partnerships. If building sustainability becomes a problem for the program, the program should look to some of the other sustainable projects and international engagements of community health centers to see if they might partner with them. (For list of health centers currently working abroad see section 3.1)
Channeling Medical Volunteerism toward Sustainable Health Change:

Rapid growth in medical volunteerism in resource-poor countries presents an opportunity for improving global health. The challenge is to ensure that the good intentions of volunteers are channeled effectively into endeavors that generate locally acceptable, sustainable changes in health. The Shoulder to Shoulder Model developed by Jeffery E. Heck, MD; Andrew Bazemore, MD, MPH; and Phil Diller, MD, PhD in 1990 in Honduras as a network of partnerships between family medicine training programs and communities in Honduras and other resource-poor countries, (See Appendix for full article) has outlined 5 ways to channel medical volunteerism toward sustainable health change:

1. **Empower Communities Through Partnerships:**
   - Partners (local health board and volunteer clinicians) should work with rural communities to form active health committees. These committees are nurtured to become capable of collaborating with their academic partners and the US communities they represent, so they can set the vision for the project and define the governance of the organization.

2. **Address Determinants of Health Broadly**
   - The community-oriented primary care (COPC) model used by health centers focuses on multiple determinants of health, including but not limited to health care, oral health, nutrition, water, sanitation, empowerment, and education. Efforts should be made to ensure international engagements are rooted in these principles of COPC as developed and demonstrated by Sydney Kark and his team in South Africa more than 60 years ago. These principles are: (1) defining and characterizing the community, (2) involving the community as partners, (3) identifying or diagnosing community health problems, (5) monitoring the outcome of the intervention to determine if specific outcomes of the intervention to determine if specific measurable outcomes have been achieved, and (6) modifying the intervention as needed to achieve the intended goals.

3. **Pursue Sustainability**
   - US partners can help enhance the effectiveness of volunteers by returning to the same place year after year. This enables health centers to engage in projects that are the priority of their community, have the approval and commitment of their community boards, and are realistically sustainable with limited funding and community participation.

Information from this section is taken from the “Shoulder to Shoulder” Model developed by Jeffery E. Heck, MD; Andrew Bazemore, MD, MPH; and Phil Diller, MD, PhD. For more information about the Shoulder to Shoulder Model, see full article “The Shoulder to Shoulder Model—Channeling Medical Volunteerism Toward Sustainable Health Change” located in the appendix.
4. Leverage Resource Partner Money and Skills
   - Resources and personnel from US health centers are usually augmented by donated funds to establish sustainable community development in poor rural communities. The national organization should support the development and startup of new programs. The US health center and its supporting community provide the financial support and volunteer efforts needed to sustain the partnerships. Additionally, departments of family medicine working at sites should be capable of galvanizing the efforts of many medical and nonmedical departments.

5. Realize Economies of Scale Through Intra-Institutional Coalitions
   - The US communities also form an organization to support the common principles and share common staff and supplies and, most importantly, ideas. This model thus combines an educational mission (training health professional learners) with long-term community development, and this is seen as an appealing form of volunteerism for medical educators and community practitioners. By developing strong community boards in poor areas and a consistent local paid staff, the program offers visionary volunteer health professionals the infrastructure on which to build lasting programs that influence the health of communities. They work in tandem to achieve a clear mission: to develop educational, nutritional, and health programs to help poor communities in resource-poor countries to achieve sustainable development and improve the overall health and well-being of their residents.
Example of a Team Leader’s Handbook Table of Contents

The following is an example table of contents from a handbook developed by Andrew Bazemore, MD; and Christy O’Dea, MD for residents and doctors preparing for work abroad in their “Shoulder to Shoulder” partner program. Your health center can use it as a model for developing your own materials to prepare your doctors and residents for international work. The full handbook is located in the appendix at the back of the toolkit.

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[7] APPENDIX:

■ Articles Sited in the Toolkit:

7.1 DRAFT: The Surgeon General’s Call to Action on Global Health 2006
   U.S. Department of Health and Human Services: Office of the Surgeon General

7.2 Going Global: Considerations for Introducing Global Health Into Family Medicine Training Programs (Labeled in Reading as: “Introducing Global health into CHC Residency Training Programs)
   Jessica Evert, MD; Andrew Bazemore, MD, MPH, Allen Hixon, MD; Kelley Withy, MD, PhD

7.3 The Shoulder to Shoulder Model –Channeling Medical Volunteerism Toward Sustainable Health Change
   Jeffrey E. Heck, MD; Andrew Bazemore, MD, MPH; Phil Diller, MD, PhD

7.4 The WHO’s World Health Report 2008: Primary Care – Now More than Ever

7.5 Shoulder to Shoulder’s Team Leader Handbook

■ Global Health Policy Readings

   The Henry J. Kaiser Family Foundation, Executive Summary: April 2009

7.7 What’s on the Agenda in Global Health? The Experts’ List for the Obama Administration
   Lindsay Morgan, Policy Analyst Center for Global Development: June 2009

■ Strengthening International Partnerships in Global Health

7.8 Commentary: Public – Private “Partnerships” in Health – a Global Call to Action
   Sania Nashtar; Corresponding Author for Health Research Policy and Systems: July 2004

■ Health Centers Working Abroad

7.9 Lutheran Medical Center: Doc’s on Mission of Mercy to Help the Poorest of the Poor

7.10 Brief Information on a Partnership for Development Between the Permanent Mission of Dominican Republic to the United Nations, Samana College Research Center , Jewish Renaissance Foundation and Medical Center
   Dr. Alan Goldsmith, President; Jewish Renaissance Foundation and Jewish Renaissance Medical Center
The Surgeon General’s Call to Action on Global Health 2006

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Surgeon General
“We have an obligation to assure something more like fairness and equity in human health. We do not have a choice, unless we plan to give up being human. The idea that all men and women are brothers and sisters is not a transient cultural notion...

It is a biological imperative”

-- Lewis Thomas, The Fragile Species

“You’ve got to be healthy and stay healthy. Without your health, you don’t have anything. You can’t provide for your family, you lose your job, you lose your house. You ain’t got nothing without your health.”

– Joe H., American from Wyandotte, Michigan.
Part I: Introduction

Purpose

In 2006, the health of the world’s citizens is remarkably uneven. A child born today in Japan, for example, can expect to live to 82 years of age on average, whereas a newborn infant born in Zimbabwe will reach his or her 34th birthday. These disparities exist in a world that is become more closely drawn together in all domains, including health. The United States has a direct and growing stake in mitigating the global risks caused by such differences in health. We have a long and enduring tradition of compassion that compels us to help those around us in need. More than a humanitarian exercise, however, improving the health of people around the world directly serves our self-interest and our national security.

The health of all peoples has been interdependent since time began. In this current age of rapid travel, international commerce, and global communication, it is clear that artificial borders and geographic distances cannot isolate the health and safety problems and concerns of people in one community from those in another. Thus, health of an individual, community, or nation is GLOBAL by nature.

This Call to Action on Global Health by the U.S. Surgeon General is directed toward all Americans. It is an invitation to enhance the national and international action on global health with the purpose of improving the world’s health.
The purpose of this Call To Action is:

1) to inform Americans on the importance of global health and the urgency of addressing the critical global health challenges of the 21st Century
2) to advocate for action to reduce the deepening disparities in global health
3) to protect the health of the American people, and
4) to elicit global cooperation and collaborative support from national and international organizations, as well as the American public, in health research and action.

What exactly is Global Health? Why is it important?

Simply put: Global health is the health of populations -- of humanity at large. It is ensuring health and safety millions of people at a time, just as family doctors care for one patient at a time. The Institute of Medicine (IOM), part of the U.S. National Academy of Science, has defined global health as referring to “health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions.”

Global health is about recognizing that the health problems seen around the globe are also seen in our own backyards. Global health problems need to be directly faced, not only for purely selfish reasons, but because humanity will be better-off because of it. We cannot overstate the reality that problems in remote parts of the globe can no longer be ignored. Diseases that Americans once read about as affecting people in regions of the world that most of us would
never visit are now capable of reaching us directly. The hunger, disease, and death resulting
from poor food and nutrition create social and political instability in many nations, and that
instability may spread to other nations as people migrate to survive. The environmental
conditions that poison our water and contaminate our air are not contained within national
boundaries, but float on winds and waves to not-so-distant places. Failing to address global
health issues outside our national border will only make the problems that much more
challenging when they enter our country.

Global health is of fundamental moral, practical, and strategic importance to the United States
for peace, prosperity, and well-being.

Caring about the health of others is a moral value shared by people of all cultures and religions.
All societies, cultures, and religions value human life. All people harbor a compassion that
drives us to help those who are suffering or in need. If we see an accident victim, a
malnourished child, or a sick or vulnerable adult, we are compelled to help. We believe that to
allow suffering to continue is inhumane. Implicit in this is a shared moral perception that taking
care of the basic health and well-being of our fellow men and women is the “right thing to do.”
This is substantiated time and time again, particularly during times of crisis, such as the 2005
hurricanes that ravaged the southern gulf and east coasts of the United States, the 2004 Tsunami
that devastated Southeast Asia, or the flooding that destroyed lives and land in Haiti in 2004.
People everywhere continue to reach out to help in whatever way possible to alleviate human
suffering.
Caring about the health of others is also of practical significance because of the interconnectedness of the world and the ability of disease to spread rapidly across borders.

Global health is the awareness that SARS can emerge in Hong Kong and almost immediately strike Toronto; it is the understanding that the Hantavirus, first seen in Korea, can turn up years later in New Mexico; it is the recognition that the hemorrhagic fever of the African interior may take root in a Western metropolis or that an influenza pandemic could emerge in humans almost anywhere in the world and spread globally within days. Global health grasps that viruses, bacteria, and parasites can cross all borders -- so the fight against them must do the same.

Caring about the health of others is of strategic significance since health diplomacy, or working with other nations on shared health goals, promotes international cooperation, is critical to the long-term health and security of the American people. It is the way to protect, promote, and advance the health and safety of the nation. A global health perspective also recognizes that health cooperation is a critical aspect of international cooperation and diplomacy. Health diplomacy also acknowledges that poor health contributes to political and economic instability, two factors that threaten world peace. In countries with an adult HIV-prevalence rate of more than 20 percent, gross domestic product (GDP) can shrink by as much as 1 to 2 percent annually. Similarly, malaria in Africa reduces annual GDP growth by one percent. This decrease exacerbates poverty and economic stagnation, and seriously undermines the viability of affected states. Health is the common currency that can be used to help countries achieve their fullest potential and improve international relations.
In sum, increased action to improve global health improves lives, reduces the spread of disease, and contributes to global political stability and economic growth.

Why now?

In 1997, the seminal U.S. Institute of Medicine report *America’s Vital Interest in Global Health*, concluded, “…the direct interests of the American people are best served when the United States acts decisively to promote health around the world.” Since 1997, the need for greater U.S. investment in global health has only deepened. The challenges we face are extraordinary, but we are not starting from ground zero: The United States is a leader, a catalyst, and a partner in global health.

The new century has brought a myriad of new challenges and opportunities in global health. Vaccines, antibiotics, clean and available water, proper environmental sanitation, and other breakthroughs in scientific and health research and technology are among the many contributions to improved health. Improved health literacy is also critical to helping people improve their own health and the health of those around them. Health literacy is the ability of an individual to access, understand, and use health-related information and services to make appropriate health decisions. Yet new emerging diseases like the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), Severe Acute Respiratory Syndrome (SARS), and Avian Influenza provide new challenges to a nation’s public health capacity. Chronic diseases such as diabetes, heart disease, and asthma have reached epidemic levels. Unprecedented flows of people and goods across borders strain existing early warning disease
surveillance systems. Poverty and health disparities are major contributors to the numerous challenges to global public health. The time to react and respond is now.

The multiple connections and interactions which are integrating countries, economies, and populations are usually today described as “globalization.” We live in an age of globalization, in which there is no longer a distinction between domestic and international health problems. Pathogens know no boundaries, and infectious diseases are carried, sometimes within hours, to our shores via travel and trade. The movement of two million people each day across national borders and the growth of international commerce contribute to health risks ranging from infectious disease spread by travelers to contaminated foodstuffs. Our response to these threats must match or surpass their speed of transmission. Failure to do so will have devastating consequences on more than just the physical health of our citizens; it will also have serious repercussions on the health of the U.S. economy and on our national security.

Globalization is also a positive force that has lead to improvements in social, economic, and political conditions worldwide. It also allows for increased information sharing for disease control and prevention. However, because of social and economic inequalities, not everyone reaps the benefits of globalization at the same time, and such disparity contributes to instability. Globalization means that countries are more interdependent than ever. No country can truly “go it alone” or try to shut out the rest of the world with respect to public health matters. To be successful in efforts to improve health status and prevent the occurrence of new disease outbreaks, Americans must adopt a global view of health. We must think beyond our borders: therefore, health is a legitimate driver of our national foreign and economic policy, and a benefit of globalization.
The new challenges and opportunities in global health increase the urgency to develop a proactive global health strategy. The United States has been a leader in addressing global health problems and continues to renew its commitment to improving global health. Through private contributions, government assistance, and other forms of technical cooperation, Americans have made significant improvements in health and development across the globe. These improvements have included developing systems for clean water and community environmental sanitation, providing basic immunizations and basic medications, and developing educational and related activities which support health systems. Together with its international partners, the United States has the demonstrated capacity to improve health and quality of life for millions.

Key messages

- Global health is important because it has a direct impact on our lives as Americans
- There are things everyone can do to improve global public health
- Partnerships, formed within the United States and globally, have the capacity to improve health and quality of life for millions

The next section will examine a few of the global health issues that must be addressed by Americans and the global community. These examples do not cover the vast spectrum of pressing global health issues. Rather, they are intended to be illustrative of some of the most critical and complex issues at hand.
DID YOU KNOW? As stated in Article 25 of the Universal Declaration of Human Rights, adopted by the General Assembly of the United Nations on December 10, 1948:

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

Part II: Global Health Issues

The following sections will address just a few areas of global health that directly affect us all and are emblematic of the threats we are likely to face in the future. The people in the stories are fictional, but they represent real world experiences. As you read this section, keep in mind that each area raises the moral, practical, or strategic concerns we described in Section I. Perhaps more importantly, this Section considers human tragedies that are often preventable or at least can be managed to reduce the threat to global health. Using health diplomacy to alleviate these tragedies is both a moral imperative and in our vital long-term national interests.
Miriam was worried. She suspected that her husband, David, was unfaithful to her when he was away from home on his job as a long-distance truck driver. One of her neighbors in their small village in Africa had contracted HIV from her husband, who worked for the same trucking company as Miriam’s husband. Miriam tried to talk to David about his sexual behavior, but he told her that it was none of her business. “How could it not be my business?” she asked herself, “Don’t I have a right to protect myself and my unborn baby from the deadly disease AIDS?”

She tried to get David to use a condom when they had sex, but he refused, and she had no way to force him to do so or to deny him sex. To make it worse, her husband refused to let her go to the doctor by herself, and if she did, he would be furious and might hurt her. If it turned out she was HIV positive, she and her husband would be shamed. She felt trapped, alone, scared, depressed, and angry, but she had nobody she felt she could talk to about this, even though she knew of a nearby clinic that provided people with medication. So Miriam just hoped and prayed that she and her baby would be lucky and spared the devastation of AIDS.

If Miriam and her baby developed AIDS, it would have been a preventable tragedy. Miriam and her unborn child would face intolerable and unnecessary suffering and injustice. She is not empowered to take control over her health and the health of her family. Furthermore, if David was being unfaithful and he was HIV positive his indiscretions would spread the disease rapidly across large distances. The spread of the HIV/AIDS has already proven to have dramatic effects on entire populations in Africa, where thousands of adults and children are suffering and dying prematurely from a preventable disease. The disease has already spread rapidly to people on
Disease has been a part of life since early times. Paintings and drawings from ancient civilizations such as that of Egypt depict humans exhibiting the symptoms or consequences of diseases such as polio. The human race learned long ago that infectious diseases do not respect national borders. The Black Death (bubonic plague) of the Middle Ages, for example, swept across Europe and killed an estimated one-quarter of the population. The worldwide influenza pandemic of 1918 resulted in some twenty to fifty million deaths. Health authorities predict that a future flu pandemic could infect anywhere from 20 to 50 percent of the world population, resulting in huge social and economic disruption, as well as extensive loss of life.

Many factors contribute to one’s vulnerability to disease. Being poor, of a disadvantaged minority group, a migrant or refugee, a child, a prisoner, or having a weak immune system due to HIV or substance abuse or malnutrition are all factors that may lead someone to become ill.

Physical and social environments also exert a profound effect on health. A wide range of conditions, such as poor sanitation, chemical toxins, inadequate access to health care, political instability, risky behavior, violence, etc., can all influence health and cause disease.

Infectious Disease
Despite the development of vaccinations, antibiotics, and other medical technologies, one-third of all deaths worldwide in 2003 were caused by infectious diseases according to the World Health Organization (WHO). Six global diseases (acute respiratory infections, HIV/AIDS, diarrhea, tuberculosis, malaria, and measles) accounted for roughly 90 percent of worldwide deaths from infectious diseases. It is especially distressing that many deaths due to infectious diseases could be prevented by existing public health strategies and the use of vaccines. Making vaccines and treatment more widely available, as well as developing vaccines and treatments against diseases for which none currently exist, would save millions of lives a year.

HIV/AIDS may be the defining medical and public health issue of our time. By 2005, HIV, the virus that causes AIDS, had infected a cumulative total of more than 60 million people, a third of who have died. More than one million Americans are living with HIV, and HIV/AIDS is an urgent and cascading problem in developing countries. According to the most recent global estimates by UNAIDS and the WHO, about 40 million people are infected with HIV globally, and 3.1 million adults and children died of AIDS in 2005. HIV/AIDS remains a constant crisis. Over the next twenty years, HIV/AIDS is expected to cause a decline in life expectancy in 51 countries. The disease, which is the fourth largest killer globally, is not spread evenly throughout Earth’s population; about 95 percent of those infected are in the developing world and most of those are in Sub-Saharan Africa. HIV is causing enormous social disruption in many countries: millions of children have become orphans, and health care workers and facilities in many areas have been overwhelmed by the number of HIV/AIDS patients requiring medical care.
Women are more vulnerable to HIV than men because of biological and cultural factors. For example, because of the anatomy of their reproductive tract women are subject to more frequent infections of the reproductive tract than men which render them more vulnerable to infection with HIV. But cultural factors are even more important than biological ones with respect to the danger of women acquiring and spreading HIV/AIDS. In many populations women lack the power and economic independence to negotiate safe sex with their partners, for example, under many circumstances they cannot insist on the use of a condom and women who exchange sex for income are in even a weaker position to insist upon safe sex. (Germain, 2002)

**Early Warning Systems: The importance of surveillance**

One of the most valuable elements in global health is the ability to detect the first signs of an outbreak of infectious disease anywhere in the world. As a result of the AIDS pandemic and the concern about a pandemic influenza, particularly the current H5N1 strain of avian influenza, or “bird flu,” an effective global surveillance network is a high priority. Stimulated in part by the AIDS pandemic, national and international groups, including the National Science and Technology Council in 1995 and the G-8 in 1997, called for the establishment of a global early-warning system for infectious diseases. Countries have been working together to help develop a global early-warning system that includes surveillance and outbreak response. Important progress has been made at the regional level, with the establishment of such international programs as the Caribbean Epidemiology Center's disease surveillance network; the Amazon and Southern Cone networks in South America; the Integrated Disease Surveillance and Epidemic Preparedness and Response Project in Africa; the Mekong Basin Disease Surveillance system in
Southeast Asia; and the International Circumpolar Surveillance system in Alaska, Canada, Greenland, and the circumpolar regions of Europe.

An immediate priority for the United States lies in disease surveillance along our borders with Mexico and Canada. Under the Security and Prosperity Partnerships of North America, HHS works to enhance infectious-disease surveillance capabilities within North America by creating public-health emergency preparedness systems along and across the U.S.-Mexico and the U.S.-Canada borders. Information about disease occurrence in the areas across and along the Southern and Northern borders is both a public health and national security imperative. The programs in development focus on early detection, accurate identification, and prompt reporting of infectious-disease outbreaks associated with potential bio-terrorism agents or other major threats to public health. The areas of primary emphasis include the training of epidemiologists, laboratory and clinical personnel, and information-technology specialists.

While HIV/AIDS attracts a great deal of international attention, other infectious diseases also have a significant impact on global health. Malaria, caused by several species of parasites in the genus *Plasmodium* and transmitted to humans by the bite of an infected mosquito, is another deadly infectious disease that continues to plague our world.

In spite of an overall decline in cases worldwide since 1930, malaria cases in Africa has actually increased during the past few decades, and the disease remains endemic in Southeast Asia and the Americas. An estimated 500 million cases of malaria occur each year, which results in one to two million deaths, mostly children less than 5 years of age. In areas of Africa with high malaria transmission, an estimated one million people die of malaria each year, over 2,700 deaths per day, or two deaths per minute. The associated morbidity of this disease is
incalculable because many of the children who survive are repeatedly infected, with resultant poor nutrition, impaired development, and, perhaps, increased susceptibility to comorbid infections and associated disease. In Latin America, approximately forty percent of the region’s 818 million people are at risk for malaria. Malaria morbidity and mortality numbers for the Americas region are 909,788 (based on number of positive blood slides), and 99 deaths, respectively for 2003. Latin America has made improvements in combating morbidity and mortality from malaria, but neglect will prejudice those improvements. Further, with evolving technology, we can reach the hard-to-serve in ways not previously possible.

Controlling malaria will contribute significantly to the internationally agreed upon development goals contained in the United Nations (UN) Millennium Declaration, which all 193 UN Member States have pledged to achieve by 2015. Beyond reducing the disease burden, a successful fight against malaria will have far-reaching impact on child morbidity and mortality, maternal health, and poverty, which in turn could increase global stability.

Malaria treatment, control and prevention should be an integral function of an effective health system, supported by strong community involvement. Sustained success in malaria reduction calls for development of the health sector; improved case management, the use of intermittent presumptive treatment programs for pregnant women, insecticide-treated bed nets, and spraying of households with insecticide.

In the past, chloroquine and sulfadoxine-pyrimethamine were highly effective standard treatments for preventing and treating malaria, but now some of the parasites have developed drug-resistance. In May 2005, the World Health Assembly (WHA), the supreme governing body of the WHO, passed by consensus Resolution WHA 58.2 for malaria control. This resolution calls for increased allocation of domestic resources; rapid scale-up of prevention, including free
or highly subsidized distribution of insecticide-treated nets to vulnerable groups; support for expanded household insecticide spraying; access to artemisinin-based combination therapy (ACT); and the development of new medicines to treat malaria, especially for children and pregnant women.

**Roll Back Malaria**

The WHO, the United Nations Children’s Fund, the United Nations Development Programme and the World Bank launched Roll Back Malaria in 1998. The goal is to halve the burden of malaria by 2010. Reducing malaria requires commitment, coordination and financial support. The core technical strategies of RBM for the sustainable control of malaria are the following:

- Improved and prompt access to treatment; increased use of insecticide-treated bed nets and control of mosquitoes; early detection of and response to malaria epidemics; and improved prevention and treatment of malaria in pregnant women in highly endemic areas. Stated simply, the RBM strategy is to combine both prevention and cure. To be successful, malaria control must be incorporated into all health and development policies, strategies and programs.

Tuberculosis (TB) also continues to be a major killer. Tuberculosis is a contagious disease, caused by the bacteria *Mycobacterium tuberculosis* (Mtb), and is spread, much like the common cold, by coughs, sneezes, talk or spit. A person can become infected when even a few infected droplets are inhaled. One third of the world’s population (approximately two billion people), is infected with Mtb. Most people who are infected are able to fight off active infection,
but may retain a latent TB (a time of infection with no signs or symptoms of active disease),
while others appear to clear the organism completely. However, the WHO estimates that nearly
eight million people develop active TB every year, almost 98 percent of whom live in the
developing world. Although a cure was discovered over fifty years ago, TB kills between two
and three million people every year, and not just in the developing world. In 2003 the 50 states
and the District of Columbia reported 14,517 cases of tuberculosis. Tuberculosis has re-emerged
along the U.S.–Mexico border. Mexicans and immigrants from other countries who move
through Mexico cross this border to migrate to the United States. A quarter of all foreign-born
tuberculosis patients in the United States are Mexican, and the United States and Mexico have a
bilateral program to issue TB bi-national cards so treatment for tuberculosis can continue in both
countries.

Of the approximate two million people who become sick with infectious tuberculosis
each year, 300,000 have infections that are resistant to the first-line drugs used to treat TB.
Tuberculosis is most often is found in the homeless and in those with HIV/AIDS. One third of
the estimated 40 million people living with HIV/AIDS are also infected with tuberculosis. Each
disease makes the other worse, accelerating the pathology caused by each infectious agent and
hastening the death of the individual. Both diseases should be treated when they are present but
there are times when an immune reconstitution syndrome develops with treatment of the HIV
infection and fatal complications, such as TB meningitis, occur. There are many clinical trials,
supported by the US National Institute of Allergy and Infectious Diseases, underway which are
investigating the best timing of treatment for people infected with both pathogens. Another
complication of co-infection is that TB is harder to diagnose in HIV-positive patients; therefore,
treatment for tuberculosis often has been absent, inconsistent or inadequate, which may
contribute to the development of drug-resistant tuberculosis. Even where effective drugs are available, curing TB demands a long continuous pattern of treatment, six to nine months or perhaps even life, until a cure is achieved in an HIV infected person.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund is a public-private foundation created to finance a dramatic turn-around in the fight against AIDS, tuberculosis, and malaria. The Global Fund receives most of its funding from national Governments; the United States is the largest contributor to the Fund, and has provided almost one-third of the $3.7 billion that it has received. The President’s 2006 budget requested an additional $300 million. AIDS, tuberculosis and malaria kill over six million people each year, and the numbers are growing. To date, the Global Fund has committed U.S.$ 3 billion in 128 countries to support aggressive interventions against all three diseases. By funding the work of new and existing programs, it can save millions of lives, stop the spread of disease and halt the devastation to families, communities and economies around the world. As a partnership between Governments, civil society, the private sector and affected communities, the Global Fund represents an innovative approach to international health financing. The Global Fund is a results-based, grant-making body to which stakeholders from developing countries submit program proposals in a competitive, peer-reviewed process. HHS is a leader in facilitating these reviews. The submission
process was designed from the start to be inclusive of community and faith-based organizations, as well as representatives from Governments.

Global spread of infectious diseases is not restricted to human-to-human transmission. Diseases found in animals that can infect humans are known as “epizootic” diseases. These diseases become particularly dangerous when they mutate to allow for human-to-human transmission. The spread of West-Nile Virus and strains of influenza, including Avian Influenza A H5N1, is initially caused by animal-to-animal transmission.

Avian Influenza H5N1 has gained significant international attention. Most experts today view the increasing possibility of a pandemic influenza as the most significant global health emergency on the immediate horizon. A pandemic is a global disease outbreak, and an influenza pandemic occurs when a new influenza A virus emerges for which there is little or no immunity in the human population, begins to cause serious illness and then spreads easily from person to person worldwide. Historically, pandemics have traveled along sea-lanes, with global spread completed within six to eight months. Air travel has shortened this timeline considerably.

The 20th Century saw three influenza pandemics. 500,000 Americans died during the “Spanish flu” of 1918, and across the world approximately 20 million to 50 million people died. In 1957-58, the “Asian flu” caused 70,000 deaths in the United States. Then in 1968-69, the “Hong Kong flu” caused about 34,000 deaths in this country. Viruses containing a combination of genes from a human influenza virus and an avian influenza virus caused both the 1957-58 and the 1968-69 pandemics. Many scientists believe the cause of the 1918 pandemic was an avian, or bird, influenza virus, like the H5N1 influenza virus that is currently circulating in many parts of the world. Scientists think the present situation might resemble that before the 1918
pandemic. Similarities between the H5N1 strain of highly pathogenic avian influenza A and the
1918 virus include the gradual adaptation of an avian virus to a human-like virus, the severity of
disease, its concentration in young and healthy people, and the occurrence of primary viral
pneumonia (which cannot be treated) in addition to secondary bacterial pneumonia (which
responds to antibiotics).

While no one can predict the timing of influenza pandemics, rapid international spread is
certain once a virus with the appropriate characteristics appears. The speed of the spread of a
disease does not predict how deadly it will be, but it raises questions about the surge capacity of
health systems in our country as well as across the world if almost simultaneous outbreaks occur.
Countries, including the United States, are already working together to take preventive measures
to prepare for a possible global outbreak of pandemic influenza.

Children and Immunizations

Children are especially vulnerable to disease and injury, but the information and
technologies exist to save the lives of millions of these children each year. Yet coverage
of many basic interventions has either slipped or stagnated. In the 1990s, levels of
immunization coverage stagnated or dropped in many countries. The WHO estimates
that 2.5 million children died in 2002 from diseases preventable by vaccines currently
recommended by WHO, plus vaccines that are soon expected. These vaccines include
measles (540,000 deaths), Haemophilus influenza type B (Hib) (386,000 deaths),
pertussis (294,000 deaths), neonatal tetanus (180,000 deaths), and tetanus (non-neonatal;
18,000 deaths). Additional deaths among children due to rotavirus, meningococcus, and
pneumococcus approximate 1.1 million. A recent assessment by the Bellagio Study
Group on Child Survival indicates a stark and representative contrast between evidence and application in resource-poor settings. The deaths of an estimated two-thirds of children less than five years old could be averted with proven interventions that can be deployed in low-income countries. (Bellagio Study Group, 2003)

While the aforementioned diseases capture significant attention in the media and elsewhere, many other infectious diseases, continue to kill huge numbers of people worldwide. Childhood diarrhea is one such deadly condition, sometimes caused by rotavirus (other causes will be discussed in other sections), a highly contagious infection that affects 130 million infants and children worldwide by age two. The virus causes diarrhea and vomiting which results in dehydration and the most serious cases require hospitalization for intravenous fluids.

Worldwide, rotavirus diarrhea results in hundreds of thousands of child deaths a year. In the United States rotavirus causes more than three million cases of childhood diarrhea each year, and leads to 55,000 to 100,000 hospitalizations and 20-100 deaths. Clinical trials for rotavirus vaccines are underway and when they are available widespread vaccination could save $500 million in health-care costs in the United States and worldwide could reduce deaths by 30 percent, and saving as many as one million children each year.

DID YOU KNOW? Just one vaccine-preventable disease, measles, was responsible for about 745,000 deaths in 2001. The measles vaccine is safe, effective and cheap, costing approximately U.S. $0.30 a dose, including needle, syringe, and disposal, and results in near-zero death rates. Some countries include measles mortality reduction strategies into their health care
programming, which may include vitamin supplementation, insecticide treated bed-netting, and other vaccinations. With intensified efforts to improve measles vaccine coverage in Africa, measles deaths fell to 454,000 in 2004, according to WHO and UNICEF.

**Chronic Disease**

Infectious diseases, however, are by no means the only cause of illness, disability and death in the world. The WHO estimated that in 2004, for example, non-communicable diseases accounted for about 60 percent of global deaths and almost half (47 percent) of the global burden of disease. The leading non-communicable diseases are cardiovascular diseases, cancers, respiratory disorders, digestive disorders, and neuropsychiatric disorders. Chronic diseases are not exclusive to the developed world. Rather, the developing world is becoming increasingly burdened with both chronic and infectious disease, partly due to the rapid adaptation of behaviors and lifestyles that adversely affect health.

The World Health Organization (WHO) reports that in 2002, approximately 16.7 million people died from cardiovascular disease (CVD). Cardiovascular disease includes coronary heart disease, stroke, hypertensive heart disease, inflammatory heart disease, rheumatic heart disease, and other heart diseases. Risk factors for CVD vary between developed and developing countries. However, among both developed and developing countries, most CVD is attributable to tobacco use, high blood pressure, high cholesterol and obesity. Coronary heart disease is decreasing in many developed countries, but it is on the rise in many developing and middle-income countries. Experts at the WHO and elsewhere attribute this change to increased longevity, urbanization, and lifestyle changes. In fact, the WHO reported in “The Atlas of Heart
in 2004 that more than 60 percent of the global burden of coronary heart disease occurs in developing countries.

Moreover, approximately 15 million people worldwide suffer a stroke every year. Approximately 5 million of these people will die, while another 5 million are left permanently disabled, leaving a burden on their families and communities. The WHO reports that while the incidence of stroke may be decreasing in many developed countries, largely as a result of better control of high blood pressure and reduced smoking, it continues to increase worldwide. This is likely attributable to the aging population, as well as uncontrolled increased blood pressure. The risk factors for cardiovascular disease and hypertension can be greatly reduced through proper diet, exercise, and medication. In fact, treating hypertension can reduce the risk of stroke by up to 40 percent. Key to achieving this reduction in risk, however, is improved health literacy.

DID YOU KNOW? Heart disease and stroke together constitute the leading cause of death worldwide, resulting in about 17 million (about one-third of) all deaths per year.

Diabetes has become one of the major causes of premature illness and death in most countries, especially because it increases the risk of CVD. An estimated six deaths per minute, or 3.2 million deaths per year, are attributed to diabetes or related conditions. In addition to the deaths resulting from the disease, diabetes leads to various disabilities, including loss of limbs and or vision, which frequently carry economic and social consequences. In 2003, the Pan American Health Organization (PAHO) reported that expenditures associated with permanent and temporary disabilities from diabetes were over 50 billion dollars in Latin America and the
Caribbean alone. These costs are in addition to those for insulin and other drugs, hospitalization, and other medical care for persons with the disease.

The *World Cancer Report* (Stewart and Kleihues, 2003) predicts that cancer rates are set to increase globally at an alarming rate, as much as 50 percent by 2020. Malignant tumors were already responsible for 6.2 million deaths internationally in 2000. Cancer has emerged as a major public health problem in developing countries, matching its effect in industrialized nations. The three leading cancer killers are lung, stomach and liver cancer. The *Cancer Report* indicated that one-third of cancer cases could be prevented through reduction of tobacco consumption, healthy lifestyle and diet, and early detection through screening.

Tobacco is the second major cause of death and the fourth most common risk factor for disease worldwide. It is responsible for approximately five million deaths each year. The economic costs of tobacco are also high, estimated to be $200 billion a year globally, with a third of this loss occurring in developing countries. The WHO reports that if current smoking patterns continue, it will cause some 10 million deaths each year by 2020. Half the people that smoke today -approximately 650 million people- will eventually be killed by tobacco. Tobacco control measures can have a significant impact on reducing tobacco consumption, hence decreasing the burden of disease and death due to tobacco use.

**The Framework Convention on Tobacco Control**

The *World Health Organization* (WHO) Framework Convention on Tobacco Control (FCTC) is the first global health treaty negotiated under the auspices of the WHO. This convention is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. It represents a paradigm shift in developing a regulatory strategy to address
addictive substances; in contrast to previous drug control treaties, the WHO FCTC asserts the importance of demand reduction strategies as well as supply reduction issues. The WHO FCTC was developed in response to the globalization of the tobacco epidemic. The spread of the tobacco epidemic is exacerbated by a variety of complex factors with cross-border effects, including trade liberalization, direct foreign investment, global marketing, transnational tobacco advertising, promotion and sponsorship, and the international movement of contraband and counterfeit cigarettes.

There are currently 168 countries who are signatories to the FCTC, and 128 who are parties to it (i.e., their national legislative bodies have approved the country’s participation). While the United States signed the FCTC treaty in May 2004, Congress has yet to ratify the it, therefore the United States has not yet become a formal party to this agreement.

Mental illness also takes a heavy toll in human misery and death. It is estimated that nearly 450 million people are afflicted with mental, neurological or behavioral problems worldwide at any given time. Moreover, the WHO estimates that depression was found to be the second leading cause of disability worldwide. Even though mental illness has high economic and social costs, stigmatization of mental health continues to have a tremendous effect on individuals who are in need of care. It causes enormous suffering and should be considered life-threatening, with approximately 873,000 people who commit suicide annually.

Nonetheless, the world has been slow to recognize and respond to mental illness. Mental health problems are frequently not considered as high a priority in health care systems as physical problems, because people often do not recognize the seriousness of mental illness and frequently lack understanding about the benefits of care and treatment. As the WHO points out,
policy makers, insurance companies, health and labor policies, and the public at large – all
discriminate between physical and mental problems. Furthermore, the WHO reports that most
middle and low-income countries devote less than 1% of their health expenditure to mental
health. Consequently mental health policies, legislation, community care facilities, and
treatments for people with mental illness are not given the priority they deserve. The 2005
*Mental Health Atlas*, published by WHO shows no substantial change in global mental health
resources since 2001, while there continue to be marked and growing differences in availability
between high- and low-income countries. For example, the WHO survey of 192 countries does
show a slight increase in the total number of psychiatrists from 3.96 to 4.15 per 100,000 people
worldwide, distribution across regions ranges from 9.8 in Europe to just 0.04 in Africa.

There are numerous other important diseases (e.g., arthritis, asthma, and pneumonia),
both infectious and non-communicable, that contribute to global health care problems, but will
not be discussed here due to space constraints. While not exhaustive, this section was intended
to highlight some of the diseases that are facing the global population.

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**Women’s Health**

Numerous studies have demonstrated that women’s health is directly linked to
women’s education and empowerment. As primary caretakers in many societies, women
play a critical role in curbing the spread of disease. Educated women are also in a better
position to care for themselves and their children. Despite improvement in the status of
the world’s women, they still face substantial discrimination in many ways. Large gaps
exist between women and men in access to education, health, nutrition, and political
power. These inequalities directly and indirectly lead to significant health problems for women that also have an impact on their families and communities.

Today many of the health challenges facing women worldwide (such as high rates of maternal mortality, HIV infection, and sexual violence against women and girls) stem from a basic denial of women’s rights as human beings. Inequality between men and women is a major threat to women’s health. In some societies where it is unacceptable for women to leave the house without their husbands’ permission, pregnant women who need medical assistance face a risk of serious complications and death if their husbands are not home to grant them permission to seek medical care. Pregnant and childbearing women die because their basic nutrition is compromised, their reproductive rights are violated, and their access to medical care is denied as a result of gender inequality (Germain, 2002). As long as these inequalities persist, health outcomes will remain far from optimal; not only for women, but for the vulnerable populations they traditionally care for, including children and the elderly. Allowing such disparity to persist presents a significant moral challenge to all populations.

Food and Nutrition

Diane was a self-proclaimed couch-potato, with a love for all things chocolate.

Unfortunately, her 13 year old daughter, Sarah, had followed her example from an early
age and was already nearing 165 pounds on her 5’1” frame. Lately Sarah had been
complaining of being more tired than usual, would sometimes get light headed, and she
was constantly drinking any beverage she could get her hands on. Diane was starting to
become concerned, so she took her daughter to the pediatrician. The doctor took some
blood samples and called them back to let them know that Sarah had developed Type II
diabetes. She would need to go on a strict diet and exercise regimen or face insulin
shots. Moreover, she needed to start monitoring her glucose level several times a day.
They left the office stunned. Diane always believed that Type II was an adult disease, but
yet her adolescent daughter was diagnosed. The doctor said the girl’s obesity, triggered
by too many sweets and junk food, and sedentary lifestyle were to blame. Diane realized
that the time had come for a change in both their lives.

Food is the sustenance of life. Yet, every year millions of people across the globe develop
some form of disease related to their diet, just like Sarah. Too much of the wrong kinds
of food, just as well as too little of nutritious foods contribute to disease and premature
death. With all the knowledge, wealth, technology and transportation mechanisms the
world has developed, there is little reason why any child or adult should suffer from poor
nutrition resulting in malnourishment or obesity today. The solutions to both problems
are well known. Yet, every nation faces issues related to food supply, food safety, and
proper nutrition.

Food and health are intimately related. Not getting enough to eat can lead to reduced
physical capacity, higher rates of illness, and premature death. Diets that are deficient in certain
vitamins or minerals can result in disease and disability. UNICEF reports that deficiencies of micronutrients such as iron, iodine, vitamin A, and folate affect nearly one-third of the world’s population, and result in reduced mental and physical development of children, poor pregnancy outcomes, diminished work capacity of adults, and increased morbidity and premature mortality among populations.

The 2006 UNICEF report “Progress for Children: A Report Card on Nutrition” cites that more than one quarter of all children under the age of five in developing countries are underweight, many to a life-threatening degree. Poor nutrition remains a global epidemic contributing to more than half of all child deaths, about 5.6 million per year. Malnourished children in South Asia, Bangladesh, India and Pakistan account for half of all the world’s underweight children: approximately 47 percent of India’s under-five population is underweight, dragging down the regional average. In the famine-prone Eastern and Southern Africa region 29 percent of children under-five years of age are underweight. Despite some improvements several countries are falling behind again, with drought-related food crises and the rise of HIV/AIDS impacting the populations dramatically. Some reports indicate that the Western and Central African regions have done better, partly due to strides made by some countries to support exclusive breastfeeding for infants and community-based health care.

Females are much more likely to suffer from malnutrition and associated health problems than males. Girls and women receive less food than men and boys when food is scarce. Women also generally receive less protein-rich food than men even when they are pregnant or nursing. This is true even though women are responsible for most of the world’s food production, processing and preparation.
Bilateral cooperation to prevent birth defects

Nearly a decade of activity between HHS/CDC and the Chinese Ministry of Health (MOH) on the control of spina bifida offers a model for collaboration. The community intervention program conducted by the Chinese MOH in collaboration with HHS/CDC demonstrated that an inexpensive nutritional supplement of folic acid (to prevent folate deficiency) taken before and during early pregnancy could reduce the occurrence of spina bifida (and anencephaly, a more severe form of the defect) by 85 percent in the northern part of China (around Beijing), where the defect is approximately 10 times more common than it is in the south around Shanghai. This definitive study has lead to the implementation of folic acid supplementation around the globe.

Maternal malnutrition is a serious problem that affects both children and their mothers. Folate deficiency results in approximately 200,000 babies born yearly with severe and crippling neural tube defects every year. Each year millions of children in the developing world suffer from growth retardation directly related to their intra-uterine conditions. Furthermore, iodine deficiency, the leading cause of preventable mental retardation, results in as many as 37 million babies a year born with learning disabilities. According to UNICEF and the Micronutrient Initiative (2004), iodine deficiency is estimated to have lowered the intellectual capacity of almost all of the 80 nations reviewed by as much as 10 to 15 percent. Decreased intellectual capacity reduces Gross Domestic Products (GDP), diminishes productivity, and impairs development of populations. Iron deficiency is a major cause of maternal deaths, and in the 6 to 24 month age group impairs the mental development of 40 percent to 60 percent of the developing world’s children. Iron deficiency in adults is so widespread that it is lowering the
energies of nations and the productivities of workforces—with estimated losses of up to 2 percent of the GDP in the worst affected countries.

Vitamin A deficiency compromises the immune systems of approximately 40 percent of the developing world’s pre-school children, leading to mortality of an estimated one million children each year. In addition, nearly three million preschool children are rendered blind as a result of vitamin A deficiency. Yet, solutions can be as simple as a capsule of vitamin A costing just a few cents delivered during immunization – a program currently saving around 350,000 lives per year by boosting immune systems. Furthermore, fortifying staple foods with key nutrients like iron and iodine is a proven way to protect millions of children against damaging deficiencies and developmental delays.

Clearly, thousands in the developing world still suffer from hunger and malnutrition, and so those who can look elsewhere for sustenance do. This contributes to waves of migration, both legal and illegal, to countries with more resources. These countries, including the United States, while better off, are not always prepared for the burden of caring for the incoming population. Working with the countries of origin, to prevent hunger and resulting migration, benefit both sides.

DID YOU KNOW? Malnutrition is the most common risk factor causing disease and injury.

Not all nutrition-related health problems are due to lack of food or of particular nutrients, however. Too much food can make an individual overweight, even obese, increasing the risk of diabetes, heart disease, and other health problems. Foods high in saturated fats can increase the body’s cholesterol level, a risk factor in heart disease and stroke. Nonetheless, even healthy foods, if consumed in excessive amounts, can result in obesity and related risks.
The links between diet, physical activity and diseases such as diabetes, hypertension and heart disease are well established. Research has demonstrated that obesity increases the risk of developing diabetes, hypertension, heart disease, stroke, colon cancer, post-menopausal breast cancer, osteoarthritis and a variety of other health problems.

In the United States, obesity has become an epidemic. Changes in lifestyles over the past few decades, such as reduced demands for physical work and an increase in dining out and consuming fast foods, have led to an increase in the weight of the average American. The U.S. Department of Health and Human Services’ Centers for Disease Control and Prevention (CDC) reported that the proportion of overweight adults increased 50 percent in ten years, and the proportion of overweight children more than doubled between 1976 and 2000. The CDC estimates 3,000 Americans a year die from complications related to obesity, and the country spends 117 billion dollars a year on disease related to overweight and obesity.

This epidemic of obesity is not unique to the United States. The WHO estimates that one billion adults worldwide are overweight, and at least 300 million are clinically obese. It is a serious threat to health in other countries as well, both developed and developing countries. As people in developing countries adopt Western lifestyles of unhealthy high fat, high sugar, low fiber, high calories diets, along with lower levels of exercise, obesity increasingly becomes a problem. Due to these lifestyle changes, diseases traditionally associated with developed countries, such as hypertension and heart disease, are increasing significantly in developing countries as well.

Food can also be a source of disease in another way. Food that has been contaminated by microorganisms, pesticide spray residues, or other agents can make people sick. In 2004, for example, 317 people became ill in Kenya and 125 died as a result of consuming maize affected
by a toxic mold (Aflatoxin) that can grow on certain crops. Many food products are imported
daily to the United States from other countries, and the U.S. Food and Drug Administration of
the Department of Health and Human Services works closely with foreign growers to ensure that
those food products are safe. In addition to accidental poisoning, health officials must also be
alert these days to the possibility of individuals such as terrorists intentionally introducing
poisonous agents into the food supply. Emergency preparedness can play a critical role in
preventing such an incident from occurring. Food production systems and corresponding food
safety and security vulnerabilities vary widely with agricultural systems, production methods,
and amount of government regulatory oversight. Only by working with the countries from
which the food originates can a safe and sufficient food supply be ensured.

Water and Air

Raul’s rural village in South America never had the luxury of being connected to city
water pipes, with clean, chlorinated water. Instead, he and his neighbors had to collect
water from rain-water collection buckets they placed outside their homes. Sometimes,
though, when the rains did not come, they had to collect water from the nearby river.
The rains had not come in a while, and Raul was forced to collect drinking water from
the river. While there, he also collected some vegetables to eat that had been watered
with water from the river. Over the next few days, he and his wife suffered terrible bouts
of diarrhea and fever. They grew increasingly weak and had no energy to go look for
food or help. There was no doctor for miles around to treat them, and even if there was,
she doubted they would be able to pay for any medicines the doctor might recommend.
Raul had no way of knowing for sure that the river was polluted by human excrement due to rains and heavy flooding upstream. However, even basic public health precautionary methods like handwashing and boiling of water or charcoal filtering can be difficult to undertake in the poorest and most remote areas. Lack of infrastructure, coupled with lack of access to health care, can create hazardous living conditions.

The physical environment exerts an enormous influence on global health. In particular, the air we breathe and the water we drink plays a major role in the state of our health. Water and air are essential to life, but can become sources of disease or factors exacerbating disease if contaminated.

Globally 2.3 billion people suffer from diseases associated with contaminated water – mostly the poor from virtually all developing countries. Water-related diseases cause an estimated 12 million deaths a year, nearly half of them due to diarrheal diseases, with children being the most likely victims. Some of the most prevalent water-borne diseases include: cholera, enterotoxigenic *Escherichia coli*, and typhoid fever. These types of diseases are prevalent where there is a lack of clean water and basic public health practices such as handwashing, proper washing of foodstuffs, and sewage removal.

DID YOU KNOW? Nearly 80 percent of childhood diseases that result in death are caused by contaminated water. (WHO and UNICEF, 2000)
Water shortages usually lead to problems of water quality since sewage, industrial waste and agricultural and urban run-off overload the capacity of bodies of water to break down or dilute these wastes. Other causes of water crises may arise from natural disasters, such as hurricanes and earthquakes, often leave many thousands of residents of the affected areas without access to safe drinking water for days and weeks after these incidents. The earthquake and tsunami of December 2004 is an example of such a disaster that left thousands temporarily without access to safe drinking water. Yet, simple preventive public health measures were rapidly implemented, and massive outbreak of disease was averted.

Rivers, oceans and the atmosphere cross national and international borders. Pollution of air and water is thus not confined to the countries in which it occurs. For example, high levels of toxic chemicals known as polychlorinated biphenyls (PCBs) have been found in Inuit people living in some of the most remote areas of the Artic Circle. Ingested PCBs can be stored in the fatty tissue of animals, and in this case elevated concentrations of PCBs were found in the blubber of whales and seals, one of the major food sources for the Inuits. (Population, 2000)

Protecting the Earth’s air and water to ensure the health of humans is therefore a global task.

Fresh water is considered a renewable resource, but there are limits on the supplies available. In many countries or regions, shortages of fresh water are the main obstacles to agricultural and industrial production. The U.S. Agency for International Development (USAID) reports that nearly half a billion people in 31 countries face serious water shortages today.

In addition to being contaminated by disease-causing microorganisms, water can be polluted by chemicals that are injurious to health. The contamination of water by heavy metals such as lead and mercury is a problem for developing and industrialized countries alike. Birth
defects, bone malformations, and brain damage are but a few of the many health problems attributed to heavy metal pollution. Uncontrolled emissions from industrial plants and the contamination of water sources from mining operations threaten drinking water quality globally. (Chanlett, 1979)

The use of pesticides is also of concern to health officials, scientists, and government leaders around the world. These chemicals can persist in the environment for long periods of time, and are often found in the fatty tissues of animals and humans exposed to them. Release of these chemicals into the air or water can negatively affect the health of biological organisms many miles from the point of discharge. Runoff from pesticides used on food crops, for example, can enter and contaminate lakes, rivers and other bodies of water. Chlorinated hydrocarbon pesticides are much more closely regulated than they once were, but they can still pose a threat to health, especially since they decompose slowly and can remain in the water or soil for long periods of time. Even the less dangerous and less persistent pesticides introduced in recent times can have negative effects on health. When such chemicals are found in water supplies, they usually occur in small amounts. Nonetheless, if consumed they may potentially cause chronic health problems such as organ failure, cancer, or birth defects. (Population, 2000)

Air pollution is a major environment-related health threat to children and a risk factor for both acute and chronic respiratory disease. While second-hand tobacco smoke and certain outdoor pollutants are known risk factors for acute respiratory infections, indoor air pollution from biomass fuel is one of the major contributors to the global burden of disease. Indoor air pollution from the combustion of coal or unprocessed biomass fuels such as wood or waste represents perhaps the largest energy-related source of ill health. In fact, biomass fuels are used to meet the energy needs of half of the world’s population. They are often burnt in open fires or
inefficient stoves in poorly ventilated houses and give off smoke and chemicals that contribute to
diseases of the lungs and heart. Because of the presence of known cancer-causing chemicals in
the indoor air, there is also an increased risk of lung cancer. Women are generally responsible
for cooking and looking after children in these homes, and they and their children are at the
greatest risk.

In addition, outdoor air pollution is a serious problem in cities throughout the world,
particularly in the megacities of developing countries. WHO estimates that a quarter of the
world population is exposed to unhealthy concentrations of air pollutants. Of those exposed,
children are particularly at risk due to the immaturity of their respiratory organ systems.
Outdoor air pollution is largely and increasingly a consequence of the combustion of fossil fuels
for transport, power generation and other human activities. Combustion processes produce a
complex mixture of pollutants that comprises both primary emissions, such as diesel soot
particles and lead, and the products of atmospheric transformation, such as ozone and sulfate
particles formed from the burning of sulfur-containing fuel. The removal of lead from gasoline
has been a major improvement to the overall health of millions of people especially children
whose developing brains were most affected, as well as to the environment. This was achievable
through massive international cooperation and understanding of this issue.

Another effect of air pollution is that the ozone layer in the stratosphere above Earth’s
atmosphere is being damaged by the release of various chemicals used in refrigerants, aerosols,
and other equipment, as well as organic solvents. Depletion of the ozone layer is likely to lead to
higher levels of ultraviolet radiation reaching the Earth’s surface. Certain wavelengths of this
radiation increase the incidence of skin cancer and cataracts in humans. (WHO, 1992; WHO,
1993)
A related issue concerns the build-up of greenhouse gases in the atmosphere, which is believed likely to lead to global warming and a rise in the sea level. The climate changes that would result from global warming could have various direct and indirect effects on the health of humans. For example, heat stress and heat stroke, which can be fatal, may become more common, especially among susceptible groups such as older adults, children, and those with heart problems. The distribution of insects and other organisms that serve as hosts to the microorganisms that cause infectious diseases is likely to be affected. This could lead to changes in disease patterns. For example, malaria might appear in areas where it is currently unknown because of the spread of the mosquito that carries the disease. Global warming could also adversely affect health if changes in rainfall diminished the variety or quantity of crops available, which could lead to or aggravate food shortages. (WHO, 1992; WHO, 1993)

Injuries and Violence

Joe Williams was enjoying his vacation abroad with his wife, 10-year old daughter, and 8-year old son. They were in the second week of their trip, and the large city they were visiting was crowded but exciting. Joe was a little nervous about driving in a foreign country where he was unsure of local driving customs and regulations, especially in this city, where the traffic was so heavy. But he gamely drove out of the hotel parking area that evening to search for a restaurant across town that was recommended by his guide book. Rush hour traffic was particularly bad that day, and suddenly a car cut in front of Joe. He hit the brakes but could not stop in time. The next thing Joe remembered was
waking up in the hospital with a broken leg. He was relieved to learn from a nurse that his wife and the children were not seriously injured. Joe reflected that they had been lucky, although the accident sure put a damper on their vacation plans.

Joe was one of millions of people injured in traffic crashes every year. In this age of global travel, it is becoming more common for persons to become involved in traffic crashes in countries other than their own. Being involved in a crash is traumatic enough in itself. Having to deal with police, insurance and the health care system in a foreign country makes the situation that more stressful.

Injuries are one of the great unrecognized problems for global health. Injuries continue to rank among one of the leading causes of death and disability, regardless of age, sex, or income. The WHO reports that almost 50 percent of the world’s injury mortality occurs in young people aged 15-44 years, the most economically productive members of the global population. They write: “Injuries have traditionally been regarded as random, unavoidable “accidents”. Within the last few decades, however, a better understanding of the nature of injuries has changed these old attitudes, and today both unintentional and intentional injuries are viewed as largely preventable events. As a result of this shift in perception, injuries and their health implications have demanded the attention of decision-makers worldwide and injury policy has been firmly placed in the public health arena. Furthermore, the growing acceptance of injuries as a preventable public health problem over the past decade or so has lead to the development of preventative strategies and, consequently, a decrease in the human death toll due to injuries in some countries.”
World wide, an estimated 1.2 million people are killed in road crashes every year, and as many as 50 million are injured. The WHO estimates that roughly 70 percent of the deaths occur in developing countries. Sixty-five percent of deaths involve pedestrians, and 35 percent of pedestrian deaths involve children. Five issues are directly involved in creating safer roads and better drivers: speed, alcohol, helmets, seat belts, and visibility. In the United States, a person dies in an alcohol-related traffic crash every three minutes. Thousands are injured every year, as well, and all are preventable through responsible behavior. Abroad, Americans and travelers visiting foreign countries are often unaware of the hazards of international road travel and may not understand road regulations, cultures, and conditions.

As countries grapple with how to reduce and eliminate such injuries, meaningful dialogues about strategies and models to prevent injury can benefit the global community. In fact, the theme for World Health Day in 2004 was “Road safety is no accident.” The idea behind the slogan is to change the perception that injuries and deaths resulting from crashes are accidental. Indeed, such harm is completely preventable through proper interventions and behavior change.

Violence and injuries significantly affect the lives and health of people in all countries. The 2002 WHO World Report on Violence and Health noted that each year more than 1.6 million people lose their lives to violence. It is the leading cause of death for people aged 15-44 years worldwide, accounting for about 14 percent of deaths among males and 7 percent among females. Yet with prevention, the disability and deaths they cause on a daily basis can be greatly reduced. Weapons, terrorists, and other contributors to violence daily cross national borders. Refugees fleeing areas of violence also move across borders, which can sometimes create
stresses on the host country if it is not prepared. Inappropriate housing settlements can become
epicenters for disease outbreaks and environmental health problems, resulting in further
suffering, disease spread, and potential clashes with local populations. Violence contributes to
instability of governments and institutions, making the world less safe. People often enter into
conflict – nationally or internationally - because they lack resources, including good health.
However, health can serve as a common currency among opposing groups and can, in fact,
potentially reduce further violent outbreaks. Health diplomacy can help reduce violence and
improve health.

It is only in recent decades, however, that violence has been treated as public health
issues. The CDC, for example, began studying injuries in the 1970s and violence prevention in
“Healthy People, stated that the consequence of violent behavior could not be ignored in the
effort to improve the nation’s health. This issue was later echoed in 1991, when former Surgeon
General C. Everett Koop wrote:

“Identifying violence as a public health issue is a relatively new idea….Over the years we
have tacitly and, I believe, mistakenly agreed that violence was the exclusive province of
the police, the courts, and the penal system….But when we ask them to concentrate more
on the prevention of violence and to provide additional services for victims, we may
begin to burden the criminal justice system beyond reason. At that point, the professions
of medicine, nursing and the health-related social services must come forward and
recognize violence as their issue and one that profoundly affects the public health.”
The 2002 World Report on Violence and Health divided the subject into seven topics: child abuse and neglect by caregivers, youth violence, violence by intimate partners, sexual violence, elder abuse, suicide, and collective violence. The report emphasized that in addition to death and disability, violence contributes to a variety of other health consequences, including depression, alcohol and substance abuse, smoking, eating and sleeping disorders, and HIV and other sexually transmitted diseases. It also stressed, however, that violence is preventable.

DID YOU KNOW? Data from the WHO indicates that more than five million people die each year as a result of violence or injuries.

The cost of violence is not only lives lost. In fact, a substantial portion of the cost of violence comes from the impact on victims' health and the related burden on health institutions. Injuries can often result in disability, chronic pain, and drastic changes in lifestyle. Whether or not someone survives a serious injury, and the chances that he or she will suffer a long-term impairment, depends on such factors as prompt and appropriate medical attention, timely transportation to a medical facility, and an adequate health care infrastructure. Furthermore millions are disabled and/or suffer psychological trauma due to violence or injuries. The mental health consequences of violence are just as serious as physical injuries and are often long lasting.

Collective violence can result from conflicts between nations and groups, state and group terrorism, gang warfare and other causes. It is estimated that 191 million people, a staggering number, died as a direct or indirect result of conflict in the twentieth century, well over half of them civilians. Death rates due to collective violence are disproportionately high in low and middle-income countries, about six times the rates seen in high-income countries. In addition to the loss of life, large numbers of people suffer physical, often disabling, injuries in violent conflicts each year. Numerous others suffer from various psychological and behavioral
problems, and conflicts can also interfere with food production and distribution, resulting in famine.

Women are the overwhelming majority of victims of sexual and intimate partner violence. In various surveys, anywhere between 10 percent and 69 percent of women responding have reported that they were physically assaulted at some point by an intimate partner. Physical violence in these relationships is also often accompanied by psychological abuse. Sexual violence is also often linked to intimate partner violence, with the evidence suggesting that almost one in four women experience sexual violence by an intimate partner. Sexual violence affects both the physical health and psychological well-being of its victims, resulting in such problems as unwanted pregnancies, HIV/AIDS, depression, post-traumatic stress disorder, and suicide.

Suicide is one of the leading causes of death globally, and was responsible for approximately one death every forty seconds in 2000. Although many more women report attempting suicide than men, men successfully commit suicide about three to four times as often as women. Psychiatric and social problems, as well as substance abuse, are significant risk factors in suicide.

The public health community has embraced the concept that violence and injuries are predictable and preventable. They are global in that they can happen to anyone, anywhere, at any time. They are human-made problems amenable to rational analysis and countermeasures. While they involve multiple segments of society, such as the criminal justice system and civil engineering, public health has a major role to play in attacking these problems by developing appropriate surveillance systems and science-based prevention strategies.
Central to achieving good health is the presence of a functioning health system. The ideal health system would empower people to obtain convenient, good quality, and affordable health information and services. What are the elements that would make this dream a reality? What exactly is a health system? The *World Health Report 2000* defines health systems as “all the organizations, institutions and resources that are devoted to producing health actions.” The four vital functions of the health system include *service provision, resource generation, financing and stewardship*. Different kinds of systems develop or evolve for various political, sociological, or historical reasons. A system can be mixed private and public, like in the United States, where care is provided by private physicians or practitioners and paid for with private health insurance, as well as public financing (Medicare and Medicaid). Or the system could be largely public, as in many other countries, where a Ministry or Department of Health employs physicians, owns hospitals, and assumes a larger burden of the cost of health care.

Health systems in all countries, developing and developed, are in need of reform. According to the World Bank, public and private expenditures on health care worldwide were $1,700 billion, about 8 percent of world economic output. (IOM, 1997) In spite of the increasing costs of health care, large portions of the world’s population have little or no access to affordable health services. Even in wealthy countries such as the United States, the health system is not working efficiently and effectively in making decent health care available to every citizen. Many countries are working to reform their health systems in an attempt to reduce costs, improve the quality of care, and assure universal access to health services.

The Institute of Medicine reports, however, there has been unfortunately relatively little exchange of information and experience among these countries. In addition, there is little
support for health systems research. A recent review (Travis, et al, 2004) points the scarcity of
health systems research globally, compared to drug development or intervention effectiveness
research. Without the opportunity to learn from others’ experiences, policy makers are left with
a great deal of uncertainty regarding the best approaches for strengthening their health systems.
Researchers and policy makers are also confounded about what works in health systems because
of the absence of agreement on how to measure health systems outcomes. There is a general
consensus that a health system’s performance should be judged on its ability to achieve improved
access, equity, quality, efficiency and sustainability of the system, but these ideals are hard to
measure. Because of the complexity of this subject, international collaboration in defining health
systems and health system outcome measures, cooperation in health systems research, as well as
exchange of information on what works are high priorities on the list of requirements to achieve
improved global health.

Conclusion -

Disease, food and nutrition, water and air, and injuries and violence have a direct impact
on the health of all people around the globe. The problems are similar, and the solutions are
similar, regardless of the country or population. The issues described in this section are more
than a problem for underdeveloped countries that are far away from the United States. Even the
most seemingly remote public health crisis can make its way to our shores, thanks to trade,
travel, and nature, itself. The world is more interconnected now than it has ever been in history,
and each person has a role to play in addressing global health concerns.
By sharing knowledge and best public health practices broadly, and by working together across nations, nations are better suited to better address the public health threats that affect all humans. Working together in health will help break down international barriers that sometimes even contribute to health problems. In short, by recognizing shared problems, countries can take steps to address them collaboratively in a way that benefits all.

**Health Disparities: Poverty and health**

In spite of the remarkable advances in medicine and public health, disparities in global health status, as revealed by numerous measures, are striking. While one-fifth of the world’s population enjoys an average life expectancy approaching eighty and a life comparatively free of disability, two-thirds of the world’s population, living in the least well-off countries of Africa, Asia and Latin America, suffer overwhelmingly from the world’s burden of illness and premature death. It has been estimated that the peoples of Sub-Saharan Africa and India together bore more than 40 percent of the total global burden of disease in 1990, although they make up only 26 percent of the world’s population. (Murray and Lopez, 1996)

Poverty and health are inextricably intertwined. The conditions typically associated with poverty, such as poor nutrition and lack of access to health care, lead to disease, disability and death, as well as social instability. On the other hand, disease and poor health is an impediment to economic progress through decreased labor productivity. It is estimated than more than one-fifth of the world’s population lives in extreme poverty. And the gap between the income of the richest 20 percent and the poorest 20 percent of the world’s population doubled between the 1960s and the 1990. Nonetheless, according to former WHO Director-General Gro Harlem
Brundtland, approximately 90 percent of global health resources are concentrated on 10 percent of the world’s health problems. Those who cannot read, obtain clean water, or avoid environmentally induced disease, and who are permanently under the threat of physical violence and the effects of crime - are invariably poor - whatever their income. (IOM, 1997)

Health disparities are by no means limited to developing countries. Great disparities exist within the populations of industrial nations as well, often based on race and class. In the United States, African Americans live, on average, five years less then the white population, and death rates for Hispanics in 2001 were significantly greater than those of the non-Hispanic white population for the four leading causes of death. Sudden infant death syndrome among American Indians and Native Alaskans occurs 2.3 times higher than among whites. Asian women have five times the rate of cervical cancer that white women do. Minorities and low-income populations have a disproportionate burden of death and disability from a variety of health conditions. These populations are less in general less likely to have health insurance and access to good medical care.

*International Health Regulations*

Another aspect of U.S. health diplomacy has been active participation in the shaping of new revisions of the International Health Regulations (IHRs). The IHRs provides tools governments and public health officials can use to control the spread of dangerous diseases. The IHRs, approved in 1969, were originally designed to help monitor three serious infectious diseases—cholera, plague, and yellow fever. By the Twenty-First Century, they sorely needed updating. This need was clear during the SARS outbreak of 2003, and then because of international
874 concern about pandemic and avian influenza. In May 2005, the WHO approved a new set of
875 health regulations to manage public health emergencies of international concern, to come into
876 force by July 2007. The revisions to the IHRs took years of often-difficult negotiations. The
877 2005 IHRs give expanded temporary authorities to the WHO during public-health emergencies
878 of international concern. The regulations respect the rights of sovereign States, while setting
879 forth clear guidelines for open and responsible disease reporting. They carry obligations for
880 Member States to strengthen prevention activities, report suspect cases and share tissue samples,
881 as well as to take appropriate safety measures at airports, ports and ground crossings to prevent
882 and contain the spread of disease, thereby ensuring the maximum security against the
883 international spread of diseases with minimum interference with world traffic. Global health
884 would clearly be enhanced if all countries voluntarily adhered immediately to the IHRs.

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887 Part III: The Way Forward

888 This Surgeon General’s Call to Action on Global Health makes clear that health issues
889 cannot be successfully dealt with solely within national boundaries. The agents that cause
890 infectious diseases cross national boundaries with people, animals, and products. Water, air and
891 other elements that make up our environment cannot be confined within the borders of individual
892 nations and the quality of these environmental resources impact on our health in important ways.
893 In today’s world, the economies of nations are closely interconnected and are significantly
894 affected by health conditions. Many health problems and factors that influence health are
895 common to multiple, or in some cases all, nations. Knowledge gained in one country about a
particular disease or risk factor is likely to be applicable in other countries as well. It is essential that nations share information and cooperate in actions related to health.

Eliminating health disparities, both among and within countries, is predicated on increasing health literacy. Even the seemingly simple things that people can do to stay healthy and safe, such as getting regular medical check-ups and eating healthy foods, can be struggles for many families. Yet, people around the globe, including highly educated individuals, have trouble understanding basic health information. Health literacy is the ability of an individual to access, understand, and use health-related information and services to make appropriate health decisions. It is estimated that in the United States alone, low health literacy adds as much as $58 billion per year to health care costs. Low health literacy is a threat to the health and well-being of all people and to the health and well-being of health care systems. Basic health education can be communicated through schools, family members, health professionals, lay community health workers, public and private institutions, and the media. Everyone has a role to play.

No one nation can independently improve health systems and health outcomes across the world. There is little question that the people of the United States will not only join with other nations help to shape the future of global health, but will offer American medical and technical expertise and economic support at the same time. A public that is literate and knowledgeable about health and works as private individuals to reduce its own risk factors and those of families is highly desirable. It is equally important that experts respectfully and effectively communicate concerning health as a regular matter, and redouble their efforts in times of crisis or impending crisis. Although great progress has been made on vaccines, drugs, improved sanitation, control of disease-transmitting insects, and effective prevention to reduce the threat of many once damaging or lethal diseases, such as HIV/AIDS, polio, malaria, smallpox, diphtheria, typhoid
fever, rubella and measles in the United States, and in some cases, worldwide, the work that remains overshadows what has been achieved. Biomedical research and concepts of global medicine in medical education as well as scientific exchanges need continual support.

Countries can learn from one another in their struggle to protect and improve their health of their populations. This exchange of information is a two-way street. Although it is true that developing countries can benefit from knowledge and use of the advanced health technologies available in industrialized nations, there is also much that the latter can learn from the former. For example, disadvantaged groups in the United States share similar health risks with resource poor nations, such as tuberculosis, micronutrient deficiencies and peri-natal infections. Thus, there are lessons to be learned domestically from research conducted in low- and middle-income nations. For example, landmark studies conducted in Tanzania demonstrate that unless drug treatment for tuberculosis is properly supervised tuberculosis rapidly becomes resistant to available drugs. This finding has been applied in community health programs in metropolitan New York and other cities where tuberculosis is a public health problem. Moreover, the most daunting problem facing national health care and national economies in the 21st century will be the increasing public share of today's health care bill, which in the United States is projected to grow to a 1.6 trillion to a 2.3 trillion in 2015. To guide health care reform, the United States and other nations can benefit from experiences of other countries which have achieved high health status and reduced health care costs in such fields as primary and ambulatory care, and other areas.

Governments and non-governmental organizations around the world are already engaged in many programs that contribute to global health. In the United States, for example, President Bush in 2003 announced his Emergency Plan for AIDS Relief, committing $15 billion over five
years for the hardest hit countries, including continuing bilateral support for more than 120
countries and enhanced focus in 15 countries in Africa, the Caribbean and Asia. The
Department of Health and Human Services (HHS) draws upon the technical expertise found in
its agencies, including the Centers for Disease Control and Prevention (CDC), the National
Institutes of Health (NIH), and the FDA, to further global health goals in a number of ways.
Through the Centers for Disease Control and Prevention, for example, the Department provides
substantial funding and technical support to the WHO Global Polio Eradication Initiative. HHS
is also actively supporting health reconstruction in war-torn countries, such as partnering in the
establishment of women’s teaching clinics in Afghanistan. Through the National Cancer
Institute, HHS is partnering in the establishment of the King Hussein Cancer Center in Jordan as
a regional cancer treatment facility. HHS works internationally across a broad range of health
issues confronting our nation and the world.

Non-governmental organizations (NGOs) are becoming increasingly important in
implementing global health programs. (Gellert, 1996) It is estimated that NGOs, many of them
quite small, provide approximately 20 percent of health aid to developing countries. (IMVA
website) Various American NGOs are involved in global health activities. Global Links, for
example, recovers unused medical supplies, equipment and furnishings from American hospitals
and makes them available to hospitals and clinics serving the poor in developing countries.
(Global Links website) Satellite develops solutions, through innovative applications of
information and communications technology, to fulfill the information needs of health
professionals working in communities around the world where medical journals and the internet
are not readily available or affordable. The Global Health Council identifies important world
health problems and reports on them to the American public, international and domestic
government agencies, academia, and the global health community in an effort to make global health a priority for everyone.

Governments and NGOs around the world are contributing to the advancement of global health. Two examples of international health activities of the French government, for example, are the provision of support for malaria research and training in Africa through its Institut de Recherche pour le Développement and a contribution of over 5 million dollars in 2003 to strengthen the battle against HIV/AIDS in Mozambique. (IRD website; Multilateral Initiative on Malaria website; Global Health Council website) The Japanese government has invested about 118 million dollars to provide grants and technical cooperation to Vietnam’s health sector since 1991. These projects cover preventive medicine as well as treatment. With respect to NGOs, examples of their contributions include the efforts of United Kingdom-based Healthlink Worldwide to improve the health of disadvantaged and vulnerable communities in developing countries through the use of health communications and support for advocacy initiatives, and the program of the Africa Foundation (based in South Africa) to provide access to drinking water to rural communities in Africa. (Healthlink website; Africa Foundation website)

In addition to governments and organizations of individual countries, various international bodies are also involved with global health. Most prominent among these is the World Health Organization (WHO) and its various regional offices, such as the Pan American Health Organization (PAHO), which is the specialized health agency of the United Nations (UN). WHO is a collaborative effort of the nations of the world, and is governed by 192 member states through the World Health Assembly. WHO is involved in more global health activities, on its own or in cooperation with governments, NGOs, and others, than can be enumerated here. Just to mention a few examples, it organizes vaccination campaigns and emergency relief health
services, collects and publishes health statistics and reports, and develops international
agreements on health issues such as tobacco control. Another international body involved with
health is the United Nations Children’s Fund (UNICEF), which operates programs in areas such
as vaccination, nutrition and HIV/AIDS.

One of the global health efforts sponsored by United Nations was the development of the
internationally agreed upon goals contained within the Millenium Declaration signed by 189
countries (including the United States) in 2000 (commonly referred to as the Millenium
Development Goals). These goals include targets for improving health in a number of areas,
such as maternal health, child mortality, environmental sanitation and HIV/AIDS. The
Declaration calls for the achievement of its goals by 2015.

Academic institutions (especially schools of medicine, nursing and public health),
corporations (especially in the health sector), and other institutions have also played, and must
continue to play, a vital role in global health. The efforts on the part of all of these groups have
led to significant improvements in health on a global basis in recent decades. Smallpox was
eliminated in the 1970s, and polio is close to being eradicated worldwide.

There are many other examples that could be cited, but a common element in all of these
achievements has been a highly effective social mobilization. For example, the Bellagio Study
Group on Child Survival Study noted that: “The child survival revolution of the 1980s was a
worldwide movement that reached beyond the public health community to mobilize parents,
teachers, village chiefs, rock stars, prominent sports people, and presidents. The actions needed
were simple, clear and communicated consistently through all available channels.”

The WHO has urged that all medical education include an international component. This
would strengthen skills in treating patients in places with no hospitals and little health care, and
include more knowledge of diseases endemic in other countries. A time spent in a health-care
system in another country and other forms of exchange programs would broaden the skills of
these new internationally skilled health-care workers. The professional visits of foreign
scientists and engineers and the training of highly qualified foreign students are important for
maintaining the vitality and quality of the U.S. research enterprise. This research, in turn,
underlies national security and the health and welfare of both our economy and society. It is
clearly in our national interest to help developing countries fight diseases such as AIDS, improve
their agricultural production, establish new industries, and generally raise their standard of
living. There is no better way to provide that help than to train young people from such countries
to become broadly competent in relevant fields of science and technology.

Thus there is room for optimism when it comes to improving global health. However, it
will take the kind of social mobilization noted above, involving people from all walks of life, to
achieve the desired outcomes. In addition, strong and unified leadership will be needed at the
international, national and community level. The following factors are among those that will be
needed for success in the endeavor to improve global health:

- research and evidence-based decisions;
- an educated and informed public;
- broad partnerships between governments, NGOs and development agencies;
- recognition of the role of women;
- systems of public health that promote equity and efficiency;
- complementary steps in strengthening education;
- adequate and targeted human and financial capital; and
- awareness and commitment to action by all sectors of society.
The understanding and support of the American people in improving global health and a sure knowledge of its relevance to their daily lives is of vital importance. An alert and informed public will help in safeguarding families and communities and in lending a hand elsewhere. Some concepts are familiar, such as the provision of aid during humanitarian disasters. Working with the great international health agencies will help us plan and work effectively with other nations and regions of the world. Health diplomacy, while not new, is increasingly important to improving global health, increasing the stability and security of our nation as well as benefiting others. Understanding the possibility of global disease spread helps each one of us to be alert to the health of the rest of the world. Health diplomacy extends the benefits of America’s medical research, among the best gifts to the world, to improve health and increase world security.

But beware the simple answer. The cure of one disease, no matter how deadly, is not the answer. Even a cure, an absolute eradication of HIV/AIDS, will not end the need for attention to better global health. Vigilance, collaboration and coordination are key. Preparing for an avian flu pandemic, whether it appears this year or the next, teaches many lessons and raises serious questions about planning. It will undoubtedly improve the ability to respond to other health emergencies, whether manmade or natural in origin. Improving the health of the peoples of the world demands a steady commitment of resources, minds and souls. To that end, the participation in and awareness of all Americans in a broad and purposeful global health endeavor will serve us and future generations.

We share one earth, regardless of our place of birth. Public health, now more than ever, is global health. We must recognize that, as human beings, we are all connected.
CALL TO ACTION:

There are steps that can be taken by individuals, institutions and governments to advance global health. The Surgeon General has identified as priorities the following activities for immediate action by the American public, health and related professionals, government, the private sector and the media to improve the situation regarding global health. With the cooperation of all of these segments of society, Americans can make a substantial contribution to the goal of improving global health.

A. American Public

The American public must become better informed on issues of global health. We suggest that Americans as individuals and in groups:

- Support increased U.S. investment in global health;
- Encourage policy makers to make global health initiatives a higher priority;
- Support non-governmental organizations involved in global health through donation of time or cash;
- Promote public awareness of what global health is and why it is important for the country;
- Improve their own health literacy as a means to improve their health and the health of the world around them;
- Practice basic hygiene, such as hand washing to prevent illness and staying home when sick to prevent transmitting your illness to others;
- Explore and promote the infusion of global health awareness in the education system; and
Work to decrease stigmatization of individuals and nations with respect to particular diseases or other health problems.

B. Professionals

Health workers and other professionals involved with health must become more knowledgeable and proactive with respect to global health activities and education. We suggest that professionals:

- Work to incorporate global health as an integral part of the curriculum of public health education;
- Encourage their professional associations to become better informed about changing patterns of disease associated with globalization;
- Support mid-level professionals and community health workers to become knowledgeable about global health and integrate a global approach in their work;
- Develop and implement research and demonstration programs around specific global public health issues;
- Encourage partnerships across disciplines and geographical borders;
- Support time-limited projects through grant funding;
- Promote and sustain projects that work, and share “best-practices” and evidence-based strategies that could be utilized globally;
- Promote health literacy as means to improve health; and
- Promote policies, activities, and partnerships that decrease “brain drain”
C. Government

Governments at all levels can have a major impact on global health through their policies and actions. Specifically we suggest the U.S. Federal Government:

- Review current global health activities and develop a strategic approach for the U.S. Government in global health;
- Consider expanding assistance to improve the health of people around the world as an element of U.S. foreign policy;
- Consider the health of people around the world as an element of U.S. foreign policy;
- Respect the value of multilateral partnerships for health, as well as enhance effective collaboration between governments to promote global health;
- Promote cooperation and exchange in health of states and cities with global partners;
- Adhere to the revised International Health Regulations (2005) as soon as possible; and
- Ratify the Framework Convention on Tobacco Control.

D. Private Sector

Commercial enterprises and non-profit institutions have an important role to play with respect to promoting global health. We suggest that the private sector undertake the following activities:

- Prioritize the development of products which respond to major global health needs;
- Promote corporate social responsibility and measures that improve public health;
- Explore and develop ways to improve health in the settings/countries where they are active, not just for their own workers;
- Increase the level of partnership designed to promote global health; and
- Work together, particularly with non-governmental organizations, to mobilize public support.
for global health.

E. Media

The media has a significant influence on the thinking of the public, government officials, industry executives, and all Americans. Therefore it can make a substantial contribution to the area of global health. We suggest the media:

- Work to expand health literacy and recognize that it can be used as tool to extend health to the world;
- Promote awareness of global health through media campaigns, programming and other outlets;
- Provide professional education for media professionals on global health;
- Foster international media collaboration to combat myths (such as the notion that polio vaccination causes sterilization);
- Encourage development of educational materials for medical professional dialog with international clients;
- Engage media personalities in promotion of global health;
- Encourage global media to integrate global health into content and advertising; and
- Encourage global media industries to partner/mentor/support developing country media
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Centers for Disease Control and Prevention, Department of Health and Human Services.


Department of Health and Human Services website (www.dhhs.gov)


Global Links website (www.globallinks.org).


International Medical Volunteers Association (IMVA) website


Millenium Development Goals website (www.developmentgoals.org)


Pan American Health Organization (PAHO) website (www.paho.org).


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Going Global: Considerations for Introducing Global Health Into Family Medicine Training Programs

Jessica Evert, MD; Andrew Bazemore, MD, MPH; Allen Hixon, MD; Kelley Withy, MD, PhD

Medical students and residents have shown increasing interest in international health experiences. Before attempting to establish a global health training program in a family medicine residency, program faculty must consider the goals of the international program, whether there are champions to support the program, the resources available, and the specific type of program that best fits with the residency. The program itself should include didactics, peer education, experiential learning in international and domestic settings, and methods for preparing learners and evaluating program outcomes. Several hurdles can be anticipated in developing global health programs, including finances, meeting curricular and supervision requirements, and issues related to employment law, liability, and sustainability.

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Interest in global health among US medical trainees has increased substantially in the past 2 decades. In 1984, 6.2% of graduating US medical students undertook international health experiences. In 2006, 27% of students participated in such experiences.¹²

Medical schools are responding to increased student demand by increasing global health curricula and experiences.³ Graduate medical education (GME) in fields as varied as surgery,⁴ emergency medicine,⁴ pediatrics,⁶ internal medicine,⁷ and family medicine⁸ are also responding to increased demand. The field of emergency medicine has gone so far as to create a consensus and standards for fellowship programs in international emergency medicine, and 6.8% of US allopathic emergency medicine programs currently offer such fellowships.⁹ Additionally, some GME activities in global health are being formally linked to training for underserved domestic populations.¹⁰

Family medicine residency programs are increasingly interested in expanding their global health training activities. A 1998 study found that 45% of programs surveyed offered some form of global health exposure, and 15% offered financial or curricular support for such activities.¹¹ Program directors are responding in part to a growing body of evidence of the benefits of global health training, including improved physical exam skills, increased resource consciousness when making diagnostic and treatment decisions, experience working with underserved populations, and increased interest in primary care.¹²-¹⁵ Further, at a time when medical students’ interest in family medicine is on the wane, programs are increasingly aware of the recruiting value of global health offerings.⁷,⁸,¹⁶

Program directors and faculty interested in expanding or establishing global activities can learn much from the lessons of existing programs. This article reviews considerations and challenges facing program directors who wish to establish or expand their global health training in family medicine residency programs.

Considerations in Establishing Global Health Training in Family Medicine

When considering the addition of global health components to their training activities, program directors must consider a number of questions. These questions pertain to goals, champions, resources, and the type of training being considered.
What Are the Goals of the Proposed Global Health Program?

In addition to training residents in the field of global health, there are often secondary goals of global health programs. It is important to explicitly define such goals at the outset of program development and to adopt the infrastructure necessary to meet those goals.

For example, a program aiming to deliver sustainable health services abroad with a mission of international education might wish to explore the formation of nonprofit entities capable of supporting extradepartmental fund-raising and the staffing needs necessary to support this aim. Formed to complement the international education activities of the Department of Family Medicine at the University of Cincinnati, the nonprofit transnational organization Shoulder-to-Shoulder now supports year-round global health service delivery and community development at sites visited by family medicine educators and trainees from six institutions. These include educators from the University of Cincinnati, the University of Rochester, the University of Pittsburgh, the University of North Carolina, Virginia Commonwealth University, and the University of Wyoming.

Educators may choose to establish a longitudinal educational mission for trainees. Family medicine educators in sites such as, for example, the University of California-San Francisco, University of Cincinnati, Marshall University, University of Rochester, and Case Western Reserve University have all started global health tracks to develop residents’ research and professional skills through scholarly projects and explicit career development mentoring. Other programs, such as those at the University of Hawaii, Maine Medical Center, and University of Colorado have created educational opportunities for trainees amidst a larger goal of expanding the family medicine model to other countries. A variety of goals are possible, and being cognizant of these during program development leads to more-valuable program evaluation and legacy.

Who Are the Champions?

Successful global health educational programs are frequently built through the tireless efforts of a few champions who can navigate the inevitable challenges of program development. Chairpersons and program directors with interest but no experience in global health education may find champions among departmental leadership but may also want to look in less-obvious places for expertise and support. Discussions with faculty, trainees, administrators, alumni, community members, and others may all help to identify early champions and spur the development of an organizing committee.

Individuals with experience in a variety of domains can be useful for global health program development, including refugee health, public health, cultural competency, regional studies, economics, patent law, infectious disease, maternal-child health, and political science. Even a little financial and academic support of such a champion can yield great results, as exemplified in the work of an individual like Dr Paul Farmer of Harvard University through his efforts to develop Partners in Health.

What Resources Are Available to Permit Global Health Training?

Understanding the landscape of support for global training in one’s academic center, hospital, or community setting is essential to the long-term success of a program. Are there deans, chairpersons, hospital administrators, consultants, teachers, community leaders, church leaders, and others who are interested in global health and who might help in developing the training program? Are there local or regional donors, corporate entities, or grants makers with shared interests or global activities that may seed the development of an international training site? A baseline assessment and documentation of one’s resources, allies, and barriers to success is important for the establishment of a successful program. Program directors may also benefit from contact gathering and information gathering at national conferences of global health educators, such as those sponsored by the Global Health Education Consortium (GHEC) and the American Academy of Family Physicians (AAFP).

What Type of Global Health Training Best Fits the Program and Its Resources?

Depending on the resources identified, some programs elect to offer tracks in global health (“tracks” usually designate a formal, longitudinal program), while others simply permit or help to arrange elective rotations for trainees. Programs may add didactic curricula, including lectures, integrated into their core didactics, block global health courses, or off-site training in tropical medicine. Other programs provide a domestic correlate to global health activities, usually focusing on underserved and immigrant populations.

It is critical for a program to understand that there is no uniform mold for global health program development. By understanding the landscape at one’s institution, a unique global health program can evolve. The most successful programs will be those that take stock of their preexisting resources (which are often scattered), unite these resources, and go forward with creativity in a spirit of sustainability.

Components of a Global Health Training Program

Didactics

Traditional didactic activities, such as conferences, visiting speakers, and faculty presentations, help build a foundation of knowledge for trainees. Tailoring these
activities to trainees’ level of interest, experience, and future plans is important. Some residents will require introductory global health training, while others with more experience in the field may need career development guidance and more-graduated discussions.

Many programs are challenged to find individuals who feel comfortable teaching about global health topics. It is often necessary to go beyond the family medicine department to maximize the quality and breadth of didactic sessions. For instance, neighboring schools of public health, other health professions, public policy, and social sciences can be excellent sources of individuals not only with qualifications and experience to teach global health but to expand the horizons of family medicine residents’ education. Resources for programs developing global training are outlined in Table 1, including published curricular resources for global health education.1,21-23

The competencies addressed by didactics and other forms of global health training have not been firmly established by the medical education community. There are currently efforts to do so within GHEC and other bodies. Houpt et al propose undergraduate competencies that span three domains: burden of global disease, traveler’s medicine, and immigrant health.24 Additionally, for graduate medical education, it is appropriate to incorporate exposure to career opportunities, both part time and full time, available to licensed physicians. Residents often seek guidance as to the “how” of global health work, rather than the basic “what” that is addressed by factually based competencies of undergraduate education.

**Peer Education**

One of the best resources for developing and expanding global health education for residents may be the residents themselves. Programs can augment their formal didactics with resident-led seminars and journal clubs. More and more students are entering medical school with significant global exposure and some with significant accomplishments in global health. Programs can capitalize on these trainees by facilitating peer education opportunities. Faculty can facilitate this process by creating or borrowing a core list of journal

### Table 1

<table>
<thead>
<tr>
<th>Resource</th>
<th>Location</th>
<th>Description</th>
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<tbody>
<tr>
<td>Supercourse—Epidemiology, the Internet, and Global Health: University of Pittsburgh</td>
<td><a href="http://www.pitt.edu/~super1/index.htm">www.pitt.edu/~super1/index.htm</a></td>
<td>More than 2,000 archived lectures, with users in developing countries in mind</td>
</tr>
<tr>
<td>Modules Project: Global Health Education Consortium</td>
<td><a href="http://www.globalhealth-ec.org/GHEC/Home/Modules.htm">www.globalhealth-ec.org/GHEC/Home/Modules.htm</a></td>
<td>100 PowerPoint-based modules in development for use in undergraduate and graduate medical education</td>
</tr>
<tr>
<td>Global Health Bibliography: Global Health Education Consortium</td>
<td><a href="http://www.globalhealth-ec.org/GHEC/Resources/GHbiblio_resources.htm">www.globalhealth-ec.org/GHEC/Resources/GHbiblio_resources.htm</a></td>
<td>Comprehensive core citations for use by students and faculty interested in global health</td>
</tr>
<tr>
<td>Global Health Wikipedia: Child and Family Health International</td>
<td><a href="http://www.cfhi.org/">www.cfhi.org/</a></td>
<td>A wiki site (like Wikipedia) for global health; currently in development</td>
</tr>
<tr>
<td>E-Learning Modules: University of Wales Swansea and University of Ibadan</td>
<td><a href="http://www.medicine.swan.ac.uk/inthealth.html">www.medicine.swan.ac.uk/inthealth.html</a></td>
<td>E-learning modules on global burden of disease, TB, malaria, HIV/AIDS, obesity, parasitology</td>
</tr>
<tr>
<td>GapMinder</td>
<td><a href="http://www.gapminder.org">www.gapminder.org</a></td>
<td>Free software to create visual aids from human development and world health statistics</td>
</tr>
<tr>
<td>Global Health E-Learning Center: USAID</td>
<td><a href="http://www.globalhealthlearning.org/">www.globalhealthlearning.org/</a></td>
<td>Online courses on a variety of public health, maternal health, disease burden topics</td>
</tr>
<tr>
<td>Information Sources: Global Health Council</td>
<td><a href="http://www.globalhealth.org/sources/">www.globalhealth.org/sources/</a></td>
<td>Information resources by a unifying organization</td>
</tr>
<tr>
<td>American Society of Tropical Medicine and Hygiene Certificate Training Programs</td>
<td><a href="http://www.astmh.org/certification/coursist.rtf">www.astmh.org/certification/coursist.rtf</a></td>
<td>Lists and describes 10 US and five international courses in tropical medicine and hygiene open to the public</td>
</tr>
<tr>
<td>International Health in the Developing World course: University of Arizona</td>
<td><a href="http://www.globalhealth.arizona.edu/IHIndex.html">www.globalhealth.arizona.edu/IHIndex.html</a></td>
<td>Intensive problem-based orientation course for senior medical students and residents about to embark on a field experience</td>
</tr>
</tbody>
</table>

USAID—United States Agency for International Development
club topics and articles that can be annually updated, such as the Global Health Bibliography created by the GHEC. Peer education not only builds the factual knowledge base but also allows residents to network and problem solve around the challenges of embarking on a career in global health.

Experiential Learning in the International Setting

When residency applicants inquire about global health opportunities on interview day, they often emphasize the opportunity to do international rotations. Implicit in global health training is the international experience component.

There are a variety of mechanisms through which residents can access training in the international setting. Resources to help residents locate international opportunities include the International Health Opportunities Database maintained by GHEC, Students for Global Health, Child and Family Health International, and Doctors for Global Health.

Some programs, such as the University of Cincinnati, have a longitudinal partnership with an overseas site that receives residents and medical students for clinical rotations. Other programs rely on residents to organize clinical rotations abroad. There are also a multitude of nonprofit organizations that facilitate such international rotations.

Some residents choose to do non-clinical global health experiences. These can range from month-long internships at the World Health Organization to conducting a local needs assessment or research project.

Experiential Learning in the Domestic Setting

The process of globalization has made local correlates to global health training readily available. Many residents’ interest in global health is linked to a dedication to domestic underserved populations. Programs, such as the University of Cincinnati’s Family Medicine International Health/Care of Underserved Populations track, have intertwined global and domestic didactics and activities together, offering opportunities for residents to care for underserved populations at home and abroad. These programs permit residents to longitudinally serve or rotate through community health centers and clinics that serve local refugee and immigrant communities.

Although resources available in developing countries are usually significantly less than those in the United States, the challenges created by low health literacy, poor transportation, and limited financial resources are comparable. Thus, domestic correlates among underserved and multicultural US patient populations can complement global health training programs and serve residents’ educational goals. In addition, correlation between domestic and international underserved populations can help to justify and fund global health activities.

Preparation and Debriefing

Preparing the learner for work in a global setting is an essential consideration in designing new global health training opportunities in family medicine residencies. Learners will be entering the program with varying degrees of experience, so preparation should be tailored accordingly. Synopses on the topic can be used to guide such preparation, which should include faculty mentoring and research skills. Debriefing should include a formal mechanism for program evaluation.

Mentoring. Structured mentoring is a critical aspect of training residents in global health. Programs short on mentors with global health experience should take advantage of existing networks of global health educators and relationships within their institution and community. Systematically identifying and listing available mentors with a description of their expertise, experience, and global contacts can foster connections between learners and mentors appropriate to their global health interests and desired experiences.

Programs can look to annual and regional organizations that host meetings and listserves, schools of public health/international affairs, and local nonprofit organizations. Table 2 outlines key organizations.

Research and Scholarly Activities

Many block electives and international experiences are built around project work, community surveys, and formal research activities. Community-based research is an excellent vehicle for residents to learn about the needs of global host communities and the effectiveness of interventions aimed at ameliorating those needs. Research can be performed through brief community assessments or participation in ongoing research projects that span visits from multiple residents.

Regardless of the form of research, significant care must be taken to ensure that residents are prepared to perform research, that the projects are feasible within trainees’ time constraints, that the research is accepted by and beneficial to the community, and that there is mentoring and support for such efforts.

Preparing residents should involve teaching residents the fundamental principles of community participatory research and basic principles of research ethics. Research projects with proper preparation often provide resources to the community not previously available and can spur community capacity building. Needs assessments help trainees and their hosts focus energies on projects that create long-term improvements in health when forethought is given to sustainability and long-term program evaluation. The importance of a longitudinal commitment by the sponsoring department or institution to a host community or institution cannot be overstated.
Program Evaluation

Evaluation is an important component of successful program continuation and funding. Program success can be defined by a variety of outcomes, including resident job satisfaction, applicant volume, patient satisfaction, faculty job satisfaction, cultural competency levels, scholarly achievements, career impact, capacity building within a host country, changes in health outcomes, attention to underserved communities, patient volume, funding secured, and program recognition.

However a program decides to measure success, it is important to do so consistently and gather such data from the outset. A common method is to survey residents before and after participation in global health programming to detect the effects of such programs. Programs with the capacity to do so may also wish to track health indicators in the population served; to compare pretests and posttests of learner knowledge, attitudes, and cultural competency; and to track students after graduation to determine longer-term influences of global activities.

Hurdles to Developing Global Health Training Programs

Finance

Financing global health experiences for learners and faculty is a hurdle all programs face, and sources of funding beyond participants themselves are available. Directors will want to become familiar with their regional fiscal intermediary’s interpretation of the Center for Medicare and Medicaid Services rules on graduate medical education payments for residents on away electives; these rules vary by location. Soliciting advice from peers at more-experienced programs may be helpful—with creative structuring of electives, some programs have been able to minimize loss of funding for resident participants on global rotations.

Private foundations or church organizations have provided considerable funding for international activities. The Foundation for the Advancement of Medical Education and Research also provides resources for international research and training, and opportunities for mini-fellowships are available through a Yale-Johnson & Johnson program. In addition, the Oregon Health and Science University outlines a number of opportunities at its Web site.

Other places to seek funding include the World Health Organization, industry with interests in a program’s regional work or activity, Department of Health and Human Services grants for residency training (for domestic or territorial activities), and international aid organizations. The US National Institutes of Health John E. Fogarty International Center publishes the Directory of International Grants and Fellowships in

Table 2
Organizations for Networking in Global Health

<table>
<thead>
<tr>
<th>Organization</th>
<th>Web Site or Listserv</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Global Health Education Consortium</td>
<td><a href="http://www.globalhealth-ec.org">www.globalhealth-ec.org</a></td>
<td>Global health educators from across North America; Web site, annual meeting, and members-only listserv provide resources for new programs</td>
</tr>
<tr>
<td>American Medical Student Association—Global Health Action Committee</td>
<td><a href="http://www.amsa.org/global/">www.amsa.org/global/</a></td>
<td>A free dynamic listserv run by a national medical student organization</td>
</tr>
<tr>
<td>University Coalitions for Global Health</td>
<td>Web site: <a href="http://www.ucgh.org">www.ucgh.org</a> Listserv: <a href="mailto:ucgh-subscribe@yahoogroups.com">ucgh-subscribe@yahoogroups.com</a></td>
<td>An initiative by Global Health Council to support program development and integration at US academic institutions</td>
</tr>
<tr>
<td>World Organization of Family Doctors (Wόνεα)</td>
<td><a href="http://www.globalfamilydoctor.com/">www.globalfamilydoctor.com/</a></td>
<td>An association of national organizations of family medicine. A resource for disseminating the family medicine model</td>
</tr>
<tr>
<td>Society of Teachers of Family Medicine International Committee</td>
<td><a href="http://www.stfm.org">www.stfm.org</a></td>
<td>Family medicine educators interested in global health training and idea sharing—a resource for networking</td>
</tr>
<tr>
<td>Shoulder to Shoulder</td>
<td><a href="http://www.shouldertoshoulder.org">www.shouldertoshoulder.org</a></td>
<td>Nonprofit supporting academic family medicine to form community partnerships in developing settings</td>
</tr>
</tbody>
</table>
Curricular Requirements

The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Family Medicine (ABFM) develop specialty-specific curricular guidelines. These guidelines determine the maximum amount of elective time a program may offer and set minimum patient numbers to be seen in the family medicine continuity clinic. The ABFM requires 40 weeks in the continuity clinic in any given year and does not allow more than 2 months in a row away from the clinic. While these rules promote continuity, they limit the amount of time available for out-of-town rotations. Programs must thus plan carefully for global health experiences if they are to meet the requirements for residency.

Supervision

Most programs require resident supervision by a board-certified physician in the specialty that is the focus of the rotation. Such individuals, however, may be limited or unavailable at many international sites. Having an on-site faculty member is the ideal way to meet the requirement. Alternatively, having program faculty or volunteer faculty travel with small groups of residents is another way to meet the requirements. Additionally, having residents focus on research versus clinical work may sidestep the requirement, as may partnering with a larger organization that goes on regular missions, such as Doctors Without Borders.

Employment Law

Residents may be contracted by hospitals, universities, or consortia. The employer must follow state law, including regulations related to worker’s compensation and disability insurance. Some state programs will not cover overseas experiences, and it may be a violation of state law to not provide this coverage, thus creating a challenging legal situation. University or hospital legal counsel will generally need to be contacted to interpret state-specific regulations.

Liability

“No I cover my trainee and faculty member or not?” is a frequent subject of discussion in the listserves and conference halls of global health education. There is limited precedent for medical tort in most countries of the developing world, but this is slowly changing amidst economic globalization. Before deciding about coverage for participants, program directors must determine their institutional policy for malpractice coverage while abroad and the policies of their insurer or university self-insurance office. If there is any flexibility left in decision making at that point, soliciting advice about malpractice law and precedents from host country contacts or global health peers may be helpful.

In some cases, liability waivers from the host government for volunteer medical workers can be obtained. Research electives may not require the same medical liability coverage as clinical rotations.

Finally, protecting participants by requiring or purchasing travel insurance, with specific coverage of medical evacuation, should be considered. Some universities build this into their student health insurance, and otherwise it may be purchased from a wide array of commercial vendors.

Sustainability

When global health experiences involve care delivery, there is a risk that the learner’s exposure will be limited to short-term treatment for acute problems. Such experiences should be avoided in favor of experiences that (1) integrate with local health systems to ensure follow-up care and (2) address the determinants of health more broadly, exposing learners to the principles of community-oriented primary care, public health, and sustainable partnerships. Absent these considerations, residents may learn and subsequently repeat an ineffective model of global health involvement. If a residency program is unable to build sustainability into its programming, the program may wish to partner with existing programs emphasizing sustainability, such as Child and Family Health International and Shoulder to Shoulder, Inc.

Conclusions

Despite the hurdles just discussed, family medicine residency programs are increasingly responsive to learner demand for global health training and experience. By strengthening the global health components of family medicine training, the field will be increasingly attractive to internationally minded medical students amidst a diminished primary care applicant pool. This will only increase as learners recognize the skills that training in family medicine offers the future global health provider.

The family medicine community should work to achieve information sharing, collaboration, and coordinated advocacy among global health educators. Family medicine educators should take part in interdisciplinary efforts to establish core competencies and to
standardize graduate medical global health education. Only through engagement can we hope to improve the quality of these endeavors and their impact on trainees and on global health.

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The Shoulder to Shoulder Model—Channeling Medical Volunteerism Toward Sustainable Health Change

Jeffery E. Heck, MD; Andrew Bazemore, MD, MPH; Phil Diller, MD, PhD

Background: Rapid growth in medical volunteerism in resource-poor countries presents an opportunity for improving global health. The challenge is to ensure that the good intentions of volunteers are channeled effectively into endeavors that generate locally acceptable, sustainable changes in health. Methods: Started in Honduras in 1990, Shoulder to Shoulder is a network of partnerships between family medicine training programs and communities in Honduras and other resource-poor countries. The program involves short-term volunteering by US health professionals collaborating with community health boards in the host countries. The program has been implemented in seven US family medicine training programs and is supported by a small international staff. Results: During the 16 years of program operation, more than 1,400 volunteers have made visits to host countries, which include Honduras, Ecuador, and Tanzania. Clinics have been established, school-based food programs and community-based water filtration programs developed, and cancer screening and pregnancy-care programs put in place. These and other programs have been implemented on a budget of less than $400,000, raised through donations and small grants. Conclusions: The Shoulder to Shoulder model allows health care professionals to channel short-term medical volunteerism into sustainable health partnerships with resource-poor communities. The resulting network of partnerships offers a powerful resource available to governments and foundations, poised to provide innovative interventions and cost-effective services directly to poor communities.

(Fam Med 2007;39(9):644-50.)
Methods
The Shoulder to Shoulder Model

The Shoulder to Shoulder model operates via multiple, longitudinal, short-term volunteer efforts in a single community. Volunteers are encouraged to initiate community assessments of the important determinants of health and work together to improve health using an existing informal community network as infrastructure. Such an approach views the determinants of health from a broadly defined set of influences on health (Figure 1). This new model of short-term volunteerism, which involves a long-term commitment from the organization providing volunteers, is a collaboration with the community and broadly views the social determinants of health results in a model that contrasts sharply with the traditional model (Table 1).

The Shoulder to Shoulder model, which combines an educational mission (training health professionals) with long-term community development, is a form of volunteerism for both medical educators and community practitioners. By developing strong community boards in poor areas and a consistent local paid staff, Shoulder to Shoulder offers volunteer health professionals the infrastructure on which to build lasting programs that can influence the health of a community. They work in tandem to achieve a clear mission: to develop educational, nutritional, and health programs that help poor communities in resource-poor countries achieve sustainable development and improve the overall health and well-being of their residents. There are five key components of the Shoulder to Shoulder model.

1) Empower Communities Through Partnership. Partners (local health board and volunteer clinicians) work with rural communities to form active health committees. These committees are nurtured to become capable of collaborating with their academic partners and the US communities they represent, so they can set the vision for the project and define the governance of the organization.

2) Address Determinants of Health Broadly. The community-oriented primary care (COPC) model is embraced by the Shoulder to Shoulder model. COPC focuses on multiple determinants of health, including but not limited to health care, oral health, nutrition, water, sanitation, empowerment, and education. Efforts at each site are rooted in the principles of COPC, as developed and demonstrated by Sydney Kark and his team in South Africa more than 60 years ago.7,8 Participants learn firsthand how to operationalize the COPC principles of (1) defining and characterizing the community, (2) involving the community as partners, (3) identifying or diagnosing community health problems, (4) designing and implementing an intervention to “treat” the community health problems, (5) monitoring the outcomes of the intervention to determine if specific measurable outcomes have been achieved, and (6) modifying the intervention as needed to achieve the intended goals.

3) Pursue Sustainability. US partners enhance the effectiveness of volunteers by returning to the same place year after year. They engage in projects that are the priority of their community, have the approval and commitment of their community boards, and are realistically sustainable with limited funding and community participation.

4) Leverage Resource Partner Money and Skills. Resources and personnel from US health centers are augmented by donated funds to establish sustainable community development in poor rural communities. The national organization of Shoulder to Shoulder supports the development and startup of new programs. The US health center and its supporting community provides the financial support and volunteer efforts needed to sustain the partnerships. Additionally, departments of family medicine working at Shoulder to Shoulder sites have proven adept at galvanizing the efforts of many medical and nonmedical departments. The original program at the University of
Cincinnati has leveraged the skills and efforts of most disciplines with its medical center, as well as those of students and faculty from schools of nursing, pharmacy, anthropology, geography, romance languages, education, and others.

(5) Realize Economies of Scale Through Intra-Institutional Coalitions. The US communities also form an organization to support the common principles and share common staff and supplies and, most importantly, ideas. This model thus combines an educational mission (training health professions learners) with long-term community development, and this is seen as an appealing form of volunteerism for medical educators and community practitioners. By developing strong community boards in poor areas and a consistent local paid staff, Shoulder to Shoulder offers visionary volunteer health professionals the infrastructure on which to build lasting programs that influence the health of communities. They work in tandem to achieve a clear mission: to develop educational, nutritional, and health programs to help poor communities in resource-poor countries achieve sustainable development and improve the overall health and well-being of their residents.

Organization, History, and Honduran Roots
Shoulder to Shoulder is a private, nonprofit, nongovernmental (NGO) organization formed in 1990 as a network of family medicine-led coalitions at academic centers across the United States. These academic medical centers partnered with nongovernmental community health boards in poor communities in Honduras to improve health through self-determined but collaborative interventions. By tapping into the wealth of skills and resources at their academic institution, the US partner is able to leverage resources and multidisciplinary teams to assist these local community boards in building a permanent primary care infrastructure that also addresses multiple other determinants of health such as nutrition, education, oral health, sanitation, and water. Shoulder to Shoulder, by being attentive to the needs of the community and by collaborating with local Hombro a Hombro (Shoulder to Shoulder) health boards, is able to make changes in the health of the communities served.

The nonprofit entity Shoulder to Shoulder was initially created as an initiative to provide supervised international experiences for University of Cincinnati College of Medicine medical students, nursing students, and residents, but the organization evolved in tandem with the interest of faculty and trainees for improving the health of the communities through development in partnership with their Honduran collaborators. These learners and their faculty began providing health care services in the Honduran state of Intibuca and collaborating with NGOs to provide a broader range of services such as nutritional support, educational programs, water projects, and other public health interventions. With the goal of local empowerment, Shoulder to Shoulder next worked with local community leaders in the mountainous town of Santa Lucia to form Hombro a Hombro, a grassroots community-based, nonprofit NGO registered in Honduras since 1996. The history of the Santa Lucia Project is shown in Table 2.

Honduras is the home of the majority of Shoulder to Shoulder activities. Honduras is the third poorest country in the Western Hemisphere, with a per capita gross national income equivalent to $1,120 US per year. The poverty rate, defined as households living on less than

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**Table 1**

Types of Short-term Volunteer Efforts

<table>
<thead>
<tr>
<th>Number of visits to the community</th>
<th>Traditional Short-term Volunteer Effort</th>
<th>New Model: (Shoulder to Shoulder Model)</th>
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<tr>
<td>Collab w/ host community</td>
<td>Minimal—limited to caring for the needs of the visitors during a “brigade”</td>
<td>Extensive involvement in planning, prioritizing projects, and monitoring effectiveness</td>
</tr>
<tr>
<td>Types of medical conditions treated</td>
<td>Acute care, surgical procedures, and sometimes initiation of treatment for chronic conditions</td>
<td>Acute and chronic care, prevention and health education</td>
</tr>
<tr>
<td>Type of volunteers utilized</td>
<td>Primarily doctors, dentists, nurses, and general helpers</td>
<td>Medical and dental personnel, including allied health, engineers, medical anthropologists and geographers, administrators, teachers, etc</td>
</tr>
<tr>
<td>Public health</td>
<td>Brief health education</td>
<td>Water, sanitation, and hygiene Health education</td>
</tr>
<tr>
<td>Determinants of health that are addressed</td>
<td>Biomedical</td>
<td>Biomedical, nutritional, educational, cultural, environmental, etc</td>
</tr>
<tr>
<td>Continuity</td>
<td>None</td>
<td>Available through local services and on follow-up visits</td>
</tr>
</tbody>
</table>
$2 per day, is 40%, while the childhood malnutrition rate is 17%. However, poverty and malnutrition rates are thought to be as high as twice the national average in the rural remote areas of western Honduras.

As the University of Cincinnati partnership with Santa Lucia grew, other academic health centers under the guidance of the more-established partnership established comparable relationships in other communities. Shoulder to Shoulder now works in six geographic regions not only in Honduras but also Ecuador and Tanzania (Figure 2).

Missions and Partners

Missions. Shoulder to Shoulder has three missions. The first is to provide medical and dental care, nutrition services, and community development in resource-poor communities. The second is to provide faculty-supervised experiences for health care providers in an international setting that enhances skills in community health, tropical medicine, cross-cultural medicine, and working in resource-poor environments. The third is to provide a setting for reflection and personal growth through service.

Partners. Seven partners (affiliates), connected through a national nonprofit hub, form Shoulder to Shoulder (Figure 3). Bound together by a common vision for sustainable development and a comprehensive view of health, these partners also share resources, personnel, infrastructure, ideas, and experience. The key partners and the details of each partnership can be found at www.shouldertoshoulder.org.

### Table 2

<table>
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<tr>
<th>Year First Addressed</th>
<th>Stage</th>
<th>Event</th>
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<tr>
<td>1990–1992</td>
<td>Establishing the Partnership Model with two communities</td>
<td>First Brigade</td>
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<td>1990–1992</td>
<td>Establishing the Partnership Model with two communities</td>
<td>Local Community Board developed</td>
</tr>
<tr>
<td>1990–1992</td>
<td>Establishing the Partnership Model with two communities</td>
<td>Developing a broader base of partners (business, academic, individuals) in the United States to support the work</td>
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<tr>
<td>1992</td>
<td>Creating the medical home to improve access to care and creating a physical connection to the community</td>
<td>Addressing the Health System Determinant</td>
</tr>
<tr>
<td>1992</td>
<td>Creating the medical home to improve access to care and creating a physical connection to the community</td>
<td>1. Year-round primary care Honduran clinician hired (1992)</td>
</tr>
<tr>
<td>1992</td>
<td>Creating the medical home to improve access to care and creating a physical connection to the community</td>
<td>2. Second Honduran physician hired in 1996.</td>
</tr>
<tr>
<td>1993</td>
<td></td>
<td>Hombro a Hombro Clinic constructed (1993)</td>
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<tr>
<td>1994</td>
<td>Implementing COPC activities</td>
<td>1. Defining the community service area</td>
</tr>
<tr>
<td>1994</td>
<td>Implementing COPC activities</td>
<td>2. Baseline assessment with community surveys, malnutrition assessments, water quality</td>
</tr>
<tr>
<td>1994</td>
<td>Implementing COPC activities</td>
<td>3. Documenting types of health and social problems</td>
</tr>
<tr>
<td>1996</td>
<td>Creating necessary legal relationships within the country and community</td>
<td>Establishing NGO status within Honduras</td>
</tr>
<tr>
<td>1998–2004</td>
<td>Addressing broader determinants of health</td>
<td>Addressing the Physical Determinants</td>
</tr>
<tr>
<td>1998–2004</td>
<td>Addressing broader determinants of health</td>
<td>1. Introducing a comprehensive water improvement and conservation program</td>
</tr>
<tr>
<td>1998–2004</td>
<td>Addressing broader determinants of health</td>
<td>2. School-based feeding program offers more complete diet including protein and calorie sources</td>
</tr>
<tr>
<td>1998–2004</td>
<td>Addressing the Health System Determinants</td>
<td>1. Midwifery training</td>
</tr>
<tr>
<td>1998–2004</td>
<td>Addressing the Health System Determinants</td>
<td>2. Expands scope of services to dental care</td>
</tr>
<tr>
<td>1998–2004</td>
<td>Addressing the Health System Determinants</td>
<td>3. Expands services to include preventive services: fluoridation of water, cervical cancer screening</td>
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<tr>
<td>2002–2006</td>
<td>Empowerment at the local level</td>
<td>Addressing the Cultural Determinants</td>
</tr>
<tr>
<td>2002–2006</td>
<td>Empowerment at the local level</td>
<td>1. Transition from a sense of hopelessness and lack of belief in potential to change to a sense of possibility, activation, and accomplishment</td>
</tr>
<tr>
<td>2002–2006</td>
<td>Empowerment at the local level</td>
<td>Addressing the Social Determinants</td>
</tr>
<tr>
<td>2002–2006</td>
<td>Empowerment at the local level</td>
<td>1. Empowers local community to apply for and build secondary school</td>
</tr>
<tr>
<td>2002–2006</td>
<td>Empowerment at the local level</td>
<td>2. School feeding program that creates new social network for parents of school-aged children</td>
</tr>
<tr>
<td>2002–2006</td>
<td>Empowerment at the local level</td>
<td>4. Scholarship program to assist students in going on for additional educational training</td>
</tr>
</tbody>
</table>

COPC—community-oriented primary care
NGO—nongovernmental organization
Results

Over the past 16 years, Shoulder to Shoulder has given more than 1,400 US citizens the opportunity to work side by side (“shoulder to shoulder”) with local community members in rural areas. Approximately half of the volunteers have been medical trainees, including medical students, residents, nursing students, and undergraduates with interests in pursuing medical careers. Approximately one fourth of the volunteers have been health care faculty, practicing physicians, nurses, and dentists. The rest have been other professional volunteers such as geographers, engineers, teachers, and a wide array of other professions and students. Volunteers not only have paid their travel and expenses ($1,200–$1,400 per 2-week trip) but have become the core financial benefactors of the organization and its ongoing efforts. They also organize US efforts to raise support and contribute in-kind goods such as medical and dental equipment, medicines, and other durable supplies.

The Shoulder to Shoulder health clinic in Santa Lucia (the founding partnership) is at the center of a comprehensive COPC effort, providing primary medical care, health education, and community resources to the most needy. The clinic has five modern exam rooms, an emergency room, laboratory and radiology services, and ultrasound and provides care to approximately 6,000 patients each year. In addition, the dental clinic provides acute, restorative, and preventive dentistry to the community. A comprehensive school-based fluoridation project provides fluoride to rural school children as part of the school-based feeding program. The clinic has a large attached dormitory for visiting brigade groups, allowing for up to 50 individuals at a time.

In Honduras, Shoulder to Shoulder operates year round with a staff of dedicated Honduran and
US family physicians and nurses. It operates a feeding center and a school-based feeding program that feeds 1,600 school children per day. In partnership with local US Rotary clubs, Rotary International, and Potters for Peace, a major effort is underway to widely distribute home-based water filtration units that enable rural homes to enjoy safe filtered water using a system that can be made locally and costs less than $20 to make.

In 2006–2007 alone, Shoulder to Shoulder has successfully screened more than 400 Honduran women for cervical cancer using aceto-white staining and direct visual cervical inspection. There are also programs to help distribute folate to women of child-bearing age through a partnership with Honduras-based Project Healthy Children. There are maternal and child health programs that include birth education and lay-midwifery training. In Santa Lucia, women are offered free pregnancy education and ultrasound screening. A program to improve the self-esteem of primary school-age girls through mentor-guided entrepreneurial clubs (*Yo Puedo*—“I can” or “I am able”) has been established in 23 rural primary schools. These *Yo Puedo* clubs identify poor children who aspire toward further education, and now there are 80 children receiving need-based scholarships to attend secondary school.

Shoulder to Shoulder interventions are facilitated by in-kind contributions and volunteer services at an efficient cost. The operational budget for these services at all Honduran sites remains under $400,000 per year, which is raised through volunteer contributions, individual donations, and several small family foundations.

The seven current partnerships have each developed a relationship based on standard principles as described above. Specific programs of the partnership vary depending on the community, the availability of resources, and the duration of the partnership. The commonalities of the model are seen in Table 3 and are beginning to support the notion that this is a replicable model. All together, the network provides services for reaching almost 50,000 poor people in several hundred small villages and leverages thousands of dollars of goods and services.

**Conclusions**

The Shoulder to Shoulder model has proven to be a scaleable approach to channeling international volunteerism into longitudinal health improvements. Over the next 3 years, with funding from the Benjamin Josephson Foundation and the Roy and Melanie

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**Table 3**

Programs of Shoulder to Shoulder

<table>
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<th>Shoulder to Shoulder Program</th>
<th>Brief Description</th>
<th>Partnerships Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Community Health Board development</td>
<td>A nongovernmental, independent board interacts with the US partner to assess the community needs, initiate programs and govern them.</td>
<td>All</td>
</tr>
<tr>
<td>Educational opportunities for US health care learners</td>
<td>Medical students, nursing students, residents, and undergraduate learners have opportunities to participate in the development of all programs and health care delivery. Learners always have faculty supervision.</td>
<td>All</td>
</tr>
<tr>
<td>Community-governed health center</td>
<td>Larger communities like the Santa Lucia Partnership have multiple services; others have clinics that primarily provide basic primary care services.</td>
<td>Santa Lucia, San Jose, El Negrito, Santa Ana, Pinares (under construction), San Marcos de Sierra (under construction), Ecuador</td>
</tr>
<tr>
<td>Nutrition programs</td>
<td>Nutrition programs are tailored to the needs of the community and may target primary school children, under age five children, or pregnant and lactating women. Others also include provision of micro nutrients.</td>
<td>Santa Lucia, Santa Ana, San Jose El Negrito</td>
</tr>
<tr>
<td>Water improvement programs</td>
<td>Programs include improving the quantity of water, water filtration systems, community education, and water conservation strategies, tailored for the needs of the community.</td>
<td>Santa Lucia, San Jose El Negrito, Pinares (under construction), Tanzania</td>
</tr>
<tr>
<td>Girls’ empowerment <em>(Yo Puedo)</em></td>
<td><em>Yo Puedo</em> aims to improve the self-esteem of girls through entrepreneurship. School-based programs help girls to develop leadership skills and organizational skills. In addition, community leaders and teachers develop new cultural attitudes that help girls to succeed.</td>
<td>Santa Lucia, Concepcion, Plans in all other Honduran communities</td>
</tr>
<tr>
<td>Dental programs</td>
<td>Ideal program consists of educational, restorative, and preventative care.</td>
<td>San Jose—Santa Lucia, Concepcion—all planned, Santa Ana—educational, Pinares—educational, preventive in planning stages</td>
</tr>
</tbody>
</table>
Sanders Foundation, Shoulder to Shoulder plans to start new partnerships, expand the scope of existing ones, and develop a stronger national infrastructure to support more partnerships. With more partners and funding, academic health centers can influence the health outcomes of people living in poor communities in a multitude of settings while providing more-meaningful experiences for volunteer health care providers and learners.

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Primary Health Care

Now More Than Ever

The World Health Report 2008

World Health Organization
Primary Health Care

Now More Than Ever

The World Health Report 2008

World Health Organization
The World Health Report 2008 was produced under the overall direction of Tim Evans (Assistant Director-General) and Wim Van Lerberghe (editor-in-chief). The principal writing team consisted of Wim Van Lerberghe, Tim Evans, Kumanan Rasanathan and Abdelhay Mechbal. Other main contributors to the drafting of the report were: Anne Andersen, David Evans, Benedicte Galichet, Alec Irwin, Mary Kay Kindhauser, Remo Meloni, Thierry Mertens, Charles Mock, Hernan Montenegro, Denis Poirignon and Dheepa Rajan. Organizational supervision of the report was provided by Ramesh Shademani.


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When I took office in 2007, I made clear my commitment to direct WHO’s attention towards primary health care. More important than my own conviction, this reflects the widespread and growing demand for primary health care from Member States. This demand in turn displays a growing appetite among policymakers for knowledge related to how health systems can become more equitable, inclusive and fair. It also reflects, more fundamentally, a shift towards the need for more comprehensive thinking about the performance of the health system as a whole.

This year marks both the 60th birthday of WHO and the 30th anniversary of the Declaration of Alma-Ata on Primary Health Care in 1978. While our global health context has changed remarkably over six decades, the values that lie at the core of the WHO Constitution and those that informed the Alma-Ata Declaration have been tested and remain true. Yet, despite enormous progress in health globally, our collective failures to deliver in line with these values are painfully obvious and deserve our greatest attention.

We see a mother suffering complications of labour without access to qualified support, a child missing out on essential vaccinations, an inner-city slum dweller living in squalor. We see the absence of protection for pedestrians alongside traffic-laden roads and highways, and the impoverishment arising from direct payment for care because of a lack of health insurance. These and many other everyday realities of life personify the unacceptable and avoidable shortfalls in the performance of our health systems.

In moving forward, it is important to learn from the past and, in looking back, it is clear that we can do better in the future. Thus, this World Health Report revisits the ambitious vision of primary health care as a set of values and principles for guiding the development of health systems. The Report represents an important opportunity to draw on the lessons of the past, consider the challenges that
lie ahead, and identify major avenues for health systems to narrow the intolerable gaps between aspiration and implementation.

These avenues are defined in the Report as four sets of reforms that reflect a convergence between the values of primary health care, the expectations of citizens and the common health performance challenges that cut across all contexts. They include:

- **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.

While universally applicable, these reforms do not constitute a blueprint or a manifesto for action. The details required to give them life in each country must be driven by specific conditions and contexts, drawing on the best available evidence. Nevertheless, there are no reasons why any country – rich or poor – should wait to begin moving forward with these reforms. As the last three decades have demonstrated, substantial progress is possible.

Doing better in the next 30 years means that we need to invest now in our ability to bring actual performance in line with our aspirations, expectations and the rapidly changing realities of our interdependent health world. United by the common challenge of primary health care, the time is ripe, now more than ever, to foster joint learning and sharing across nations to chart the most direct course towards health for all.

---

Dr Margaret Chan  
Director-General  
World Health Organization
Primary Health Care
Now More Than Ever
Introduction and Overview

Why a renewal of primary health care (PHC), and why now, more than ever? The immediate answer is the palpable demand for it from Member States – not just from health professionals, but from the political arena as well. Globalization is putting the social cohesion of many countries under stress, and health systems, as key constituents of the architecture of contemporary societies, are clearly not performing as well as they could and as they should. People are increasingly impatient with the inability of health services to deliver levels of national coverage that meet stated demands and changing needs, and with their failure to provide services in ways that correspond to their expectations. Few would disagree that health systems need to respond better – and faster – to the challenges of a changing world. PHC can do that.
There is today a recognition that populations are left behind and a sense of lost opportunities that are reminiscent of what gave rise, thirty years ago, to Alma-Ata’s paradigm shift in thinking about health. The Alma-Ata Conference mobilized a “Primary Health Care movement” of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the “politically, socially and economically unacceptable” health inequalities in all countries. The Declaration of Alma-Ata was clear about the values pursued: social justice and the right to better health for all, participation and solidarity. There was a sense that progress towards these values required fundamental changes in the way health-care systems operated and harnessed the potential of other sectors.

The translation of these values into tangible reforms has been uneven. Nevertheless, today, health equity enjoys increased prominence in the discourse of political leaders and ministries of health, as well as of local government structures, professional organizations and civil society organizations.

The PHC values to achieve health for all require health systems that “Put people at the centre of health care”. What people consider desirable ways of living as individuals and what they expect for their societies – i.e. what people value – constitute important parameters for governing the health sector. PHC has remained the benchmark for most countries’ discourse on health precisely because the PHC movement tried to provide rational, evidence-based and anticipatory responses to health needs and to these social expectations. Achieving this requires trade-offs that must start by taking into account citizens’ “expectations about health and health care” and ensuring “that [their] voice and choice decisively influence the way in which health services are designed and operate”. A recent PHC review echoes this perspective as the “right to the highest attainable level of health”, “maximizing equity and solidarity” while being guided by “responsiveness to people’s needs”. Moving towards health for all requires that health systems respond to the challenges of a changing world and growing expectations for better performance. This involves substantial reorientation and reform of the ways health systems operate in society today: those reforms constitute the agenda of the renewal of PHC.

Responding to the challenges of a changing world

On the whole, people are healthier, wealthier and live longer today than 30 years ago. If children were still dying at 1978 rates, there would have been 16.2 million deaths globally in 2006. In fact, there were only 9.5 million such deaths. This difference of 6.7 million is equivalent to 18 329 children’s lives being saved every day. The once revolutionary notion of essential drugs has become commonplace. There have been significant improvements in access to water, sanitation and antenatal care.

This shows that progress is possible. It can also be accelerated. There have never been more resources available for health than now. The global health economy is growing faster than gross domestic product (GDP), having increased its share from 8% to 8.6% of the world’s GDP between 2000 and 2005. In absolute terms, adjusted for inflation, this represents a 35% growth in the world’s expenditure on health over a five-year period. Knowledge and understanding of health are growing rapidly. The accelerated technological revolution is multiplying the potential for improving health and transforming health literacy in a better-educated and modernizing global society. A global stewardship is emerging: from intensified exchanges between countries, often in recognition of shared threats, challenges or opportunities; from growing solidarity; and from the global commitment to eliminate poverty exemplified in the Millennium Development Goals (MDGs).

However, there are other trends that must not be ignored. First, the substantial progress in health over recent decades has been deeply unequal, with convergence towards improved health in a large part of the world, but at the same time, with a considerable number of countries increasingly lagging behind or losing ground. Furthermore, there is now ample documentation – not available 30 years ago – of considerable and often growing health inequalities within countries.
Second, the nature of health problems is changing in ways that were only partially anticipated, and at a rate that was wholly unexpected. Ageing and the effects of ill-managed urbanization and globalization accelerate worldwide transmission of communicable diseases, and increase the burden of chronic and noncommunicable disorders. The growing reality that many individuals present with complex symptoms and multiple illnesses challenges service delivery to develop more integrated and comprehensive case management. A complex web of interrelated factors is at work, involving gradual but long-term increases in income and population, climate change, challenges to food security, and social tensions, all with definite, but largely unpredictable, implications for health in the years ahead.

Third, health systems are not insulated from the rapid pace of change and transformation that is an essential part of today’s globalization. Economic and political crises challenge state and institutional roles to ensure access, delivery and financing. Unregulated commercialization is accompanied by a blurring of the boundaries between public and private actors, while the negotiation of entitlement and rights is increasingly politicized. The information age has transformed the relations between citizens, professionals and politicians.

In many regards, the responses of the health sector to the changing world have been inadequate and naïve. Inadequate, insofar as they not only fail to anticipate, but also to respond appropriately: too often with too little, too late or too much in the wrong place. Naïve insofar as a system’s failure requires a system’s solution – not a temporary remedy. Problems with human resources for public health and health care, finance, infrastructure or information systems invariably extend beyond the narrowly defined health sector, beyond a single level of policy purview and, increasingly, across borders: this raises the benchmark in terms of working effectively across government and stakeholders.

While the health sector remains massively under-resourced in far too many countries, the resource base for health has been growing consistently over the last decade. The opportunities this growth offers for inducing structural changes and making health systems more effective and equitable are often missed. Global and, increasingly, national policy formulation processes have focused on single issues, with various constituencies competing for scarce resources, while scant attention is given to the underlying constraints that hold up health systems development in national contexts. Rather than improving their response capacity and anticipating new challenges, health systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a clear sense of direction.

Today, it is clear that left to their own devices, health systems do not gravitate naturally towards the goals of health for all through primary health care as articulated in the Declaration of Alma-Ata. Health systems are developing in directions that contribute little to equity and social justice and fail to get the best health outcomes for their money. Three particularly worrisome trends can be characterized as follows:

- health systems that focus disproportionately on a narrow offer of specialized curative care;
- health systems where a command-and-control approach to disease control, focused on short-term results, is fragmenting service delivery;
- health systems where a hands-off or laissez-faire approach to governance has allowed unregulated commercialization of health to flourish.

These trends fly in the face of a comprehensive and balanced response to health needs. In a number of countries, the resulting inequitable access, impoverishing costs, and erosion of trust in health care constitute a threat to social stability.

**Growing expectations for better performance**

The support for a renewal of PHC stems from the growing realization among health policy-makers that it can provide a stronger sense of direction and unity in the current context of fragmentation of health systems, and an alternative to the assorted quick fixes currently touted as cures for the health sector’s ills. There is also a growing realization that conventional health-care
delivery, through different mechanisms and for different reasons, is not only less effective than it could be, but suffers from a set of ubiquitous shortcomings and contradictions that are summarized in Box 1.

The mismatch between expectations and performance is a cause of concern for health authorities. Given the growing economic weight and social significance of the health sector, it is also an increasing cause for concern among politicians: it is telling that health-care issues were, on average, mentioned more than 28 times in each of the recent primary election debates in the United States\textsuperscript{22}. Business as usual for health systems is not a viable option. If these shortfalls in performance are to be redressed, the health problems of today and tomorrow will require stronger collective management and accountability guided by a clearer sense of overall direction and purpose.

Indeed, this is what people expect to happen. As societies modernize, people demand more from their health systems, for themselves and their families, as well as for the society in which they live. Thus, there is increasingly popular support for better health equity and an end to exclusion; for health services that are centred on people’s needs and expectations; for health security for the communities in which they live; and for a say in what affects their health and that of their communities\textsuperscript{23}.

These expectations resonate with the values that were at the core of the Declaration of Alma-Ata. They explain the current demand for a better alignment of health systems with these values and provide today’s PHC movement with reinvigorated social and political backing for its attempts to reform health systems.

**Box 1 Five common shortcomings of health-care delivery**

*Inverse care.* People with the most means – whose needs for health care are often less – consume the most care, whereas those with the least means and greatest health problems consume the least\textsuperscript{10}. Public spending on health services most often benefits the rich more than the poor\textsuperscript{11} in high- and low-income countries alike\textsuperscript{12,13}.

*Impoverishing care.* Wherever people lack social protection and payment for care is largely out-of-pocket at the point of service, they can be confronted with catastrophic expenses. Over 100 million people annually fall into poverty because they have to pay for health care\textsuperscript{14}.

*Fragmented and fragmenting care.* The excessive specialization of health-care providers and the narrow focus of many disease control programmes discourage a holistic approach to the individuals and the families they deal with and do not appreciate the need for continuity in care\textsuperscript{15}. Health services for poor and marginalized groups are often highly fragmented and severely under-resourced\textsuperscript{16}, while development aid often adds to the fragmentation\textsuperscript{17}.

*Unsafe care.* Poor system design that is unable to ensure safety and hygiene standards leads to high rates of hospital-acquired infections, along with medication errors and other avoidable adverse effects that are an underestimated cause of death and ill-health\textsuperscript{18}.

*Misdirected care.* Resource allocation clusters around curative services at great cost, neglecting the potential of primary prevention and health promotion to prevent up to 70% of the disease burden\textsuperscript{19,20}. At the same time, the health sector lacks the expertise to mitigate the adverse effects on health from other sectors and make the most of what these other sectors can contribute to health\textsuperscript{21}.

**From the packages of the past to the reforms of the future**

Rising expectations and broad support for the vision set forth in Alma-Ata’s values have not always easily translated into effective transformation of health systems. There have been circumstances and trends from beyond the health sector – structural adjustment, for example – over which the PHC movement had little influence or control. Furthermore, all too often, the PHC movement has oversimplified its message, resulting in one-size-fits-all recipes, ill-adapted to different contexts and problems\textsuperscript{24}. As a result, national and global health authorities have at times seen PHC not as a set of reforms, as was intended, but as one health-care delivery programme among many, providing poor care for poor people. Table 1 looks at different dimensions of early attempts at implementing PHC and contrasts this with current approaches. Inherent in this evolution is recognition that providing a sense of direction to health systems requires a set of specific and context-sensitive reforms that respond to the health challenges of today and prepare for those of tomorrow.
The focus of these reforms goes well beyond “basic” service delivery and cuts across the established boundaries of the building blocks of national health systems. For example, aligning health systems based on the values that drive PHC will require ambitious human resources policies. However, it would be an illusion to think that these can be developed in isolation from financing or service delivery policies, civil service reform and arrangements dealing with the cross-border migration of health professionals.

At the same time, PHC reforms, and the PHC movement that promotes them, have to be more responsive to social change and rising expectations that come with development and modernization. People all over the world are becoming more vocal about health as an integral part of how they and their families go about their everyday lives, and about the way their society deals with health and health care. The dynamics of demand must find a voice within the policy and decision-making processes. The necessary reorientation of health systems has to be based on sound scientific evidence and on rational management of uncertainty, but it should also integrate what people expect of health and health care for themselves, their families and their society. This requires delicate trade-offs and negotiation with multiple stakeholders that imply a stark departure from the linear, top-down models of the past. Thus, PHC reforms today are neither primarily defined by the component elements they address, nor merely by the choice of disease control interventions to be scaled up, but by the social dynamics that define the role of health systems in society.

Table 1 How experience has shifted the focus of the PHC movement

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<th>EARLY ATTEMPTS AT IMPLEMENTING PHC</th>
<th>CURRENT CONCERNS OF PHC REFORMS</th>
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<td>Extended access to a basic package of health interventions and essential drugs for the rural poor</td>
<td>Transformation and regulation of existing health systems, aiming for universal access and social health protection</td>
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<td>Concentration on mother and child health</td>
<td>Dealing with the health of everyone in the community</td>
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<tr>
<td>Focus on a small number of selected diseases, primarily infectious and acute</td>
<td>A comprehensive response to people’s expectations and needs, spanning the range of risks and illnesses</td>
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<td>Improvement of hygiene, water, sanitation and health education at village level</td>
<td>Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards</td>
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<tr>
<td>Simple technology for volunteer, non-professional community health workers</td>
<td>Teams of health workers facilitating access to and appropriate use of technology and medicines</td>
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<tr>
<td>Participation as the mobilization of local resources and health-centre management through local health committees</td>
<td>Institutionalized participation of civil society in policy dialogue and accountability mechanisms</td>
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<td>Government-funded and delivered services with a centralized top-down management</td>
<td>Pluralistic health systems operating in a globalized context</td>
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<td>Management of growing scarcity and downsizing</td>
<td>Guiding the growth of resources for health towards universal coverage</td>
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<td>Bilateral aid and technical assistance</td>
<td>Global solidarity and joint learning</td>
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<td>Primary care as the antithesis of the hospital</td>
<td>Primary care as coordinator of a comprehensive response at all levels</td>
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<td>PHC is cheap and requires only a modest investment</td>
<td>PHC is not cheap: it requires considerable investment, but it provides better value for money than its alternatives</td>
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Four sets of PHC reforms
This report structures the PHC reforms in four groups that reflect the convergence between the evidence on what is needed for an effective response to the health challenges of today’s world, the values of equity, solidarity and social justice that drive the PHC movement, and the growing expectations of the population in modernizing societies (Figure 1):

- 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 – universal coverage reforms;
- reforms that reorganize health services as primary care, i.e. 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 – service delivery reforms;
- reforms that secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across sectors – public policy reforms;
- 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 required by the complexity of contemporary health systems – leadership reforms.

The first of these four sets of reforms aims at diminishing exclusion and social disparities in health. Ultimately, the determinants of health inequality require a societal response, with political and technical choices that affect many different sectors. Health inequalities are also shaped by the inequalities in availability, access and quality of services, by the financial burden these impose on people, and even by the linguistic, cultural and gender-based barriers that are often embedded in the way in which clinical practice is conducted\(^1\).

If health systems are to reduce health inequalities, a precondition is to make services available to all, i.e. to bridge the gap in the supply of services. Service networks are much more extensive today than they were 30 years ago, but large population groups have been left behind. In some places, war and civil strife have destroyed infrastructure, in others, unregulated commercialization has made services available, but not necessarily those that are needed. Supply gaps are still a reality in many countries, making extension of their service networks a priority concern, as was the case 30 years ago.

As the overall supply of health services has improved, it has become more obvious that barriers to access are important factors of inequity: user fees, in particular, are important sources of exclusion from needed care. Moreover, when people have to purchase health care at a price that is beyond their means, a health problem can quickly precipitate them into poverty or bankruptcy\(^14\). That is why extension of the supply of services has to go hand-in-hand with social health protection, through pooling and pre-payment instead of out-of-pocket payment of user fees. The reforms to bring about universal coverage – i.e. universal access combined with social health protection – constitute a necessary condition to improved health equity. As systems that have achieved near universal coverage show, such reforms need to be complemented with another set of proactive measures to reach the unreached: those for whom service availability and social protection...
does too little to offset the health consequences of social stratification. Many individuals in this group rely on health-care networks that assume the responsibility for the health of entire communities. This is where a second set of reforms, the service delivery reforms, comes in.

These service delivery reforms are meant to transform conventional health-care delivery into primary care, optimizing the contribution of health services – local health systems, health-care networks, health districts – to health and equity while responding to the growing expectations for “putting people at the centre of health care, harmonizing mind and body, people and systems”\(^2\). These service delivery reforms are but one subset of PHC reforms, but one with such a high profile that it has often masked the broader PHC agenda. The resulting confusion has been compounded by the oversimplification of what primary care entails and of what distinguishes it from conventional health-care delivery (Box 2)\(^2\).

There is a substantial body of evidence on the comparative advantages, in terms of effectiveness and efficiency, of health care organized as people-centred primary care. Despite variations in the specific terminology, its characteristic features (person-centredness, comprehensiveness and integration, continuity of care, and participation of patients, families and communities) are well identified\(^15,27\). Care that exhibits these features requires health services that are organized accordingly, with close-to-client multidisciplinary teams that are responsible for a defined population, collaborate with social services and other sectors, and coordinate the contributions of hospitals, specialists and community organizations. Recent economic growth has brought additional resources to health. Combined with the growing demand for better performance, this creates major opportunities to reorient existing health services towards primary care – not only in well-resourced settings, but also where money is tight and needs are high. In the many low- and middle-income countries where the supply of services is in a phase of accelerated expansion, there is an opportunity now to chart a course that may avoid repeating some of the mistakes high-income countries have made in the past.

Primary care can do much to improve the health of communities, but it is not sufficient to respond to people’s desires to live in conditions that protect their health, support health equity

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**Box 2 What has been considered primary care in well-resourced contexts has been dangerously oversimplified in resource-constrained settings**

Primary care has been defined, described and studied extensively in well-resourced contexts, often with reference to physicians with a specialization in family medicine or general practice. These descriptions provide a far more ambitious agenda than the unacceptably restrictive and off-putting primary-care recipes that have been touted for low-income countries\(^27,28\):

- primary care provides a place to which people can bring a wide range of health problems – it is not acceptable that in low-income countries primary care would only deal with a few “priority diseases”;
- primary care is a hub from which patients are guided through the health system – it is not acceptable that, in low-income countries, primary care would be reduced to a stand-alone health post or isolated community-health worker;
- primary care facilitates ongoing relationships between patients and clinicians, within which patients participate in decision-making about their health and health care; it builds bridges between personal health care and patients’ families and communities – it is not acceptable that, in low-income countries, primary care would be restricted to a one-way delivery channel for priority health interventions;
- primary care opens opportunities for disease prevention and health promotion as well as early detection of disease – it is not acceptable that, in low-income countries, primary care would just be about treating common ailments;
- primary care requires teams of health professionals: physicians, nurse practitioners, and assistants with specific and sophisticated biomedical and social skills – it is not acceptable that, in low-income countries, primary care would be synonymous with low-tech, non-professional care for the rural poor who cannot afford any better;
- primary care requires adequate resources and investment, and can then provide much better value for money than its alternatives – it is not acceptable that, in low-income countries, primary care would have to be financed through out-of-pocket payments on the erroneous assumption that it is cheap and the poor should be able to afford it.
and enable them to lead the lives that they value. People also expect their governments to put into place an array of public policies to deal with health challenges, such as those posed by urbanization, climate change, gender discrimination or social stratification.

These public policies encompass the technical policies and programmes dealing with priority health problems. These programmes can be designed to work through, support and give a boost to primary care, or they can neglect to do this and, however unwillingly, undermine efforts to reform service delivery. Health authorities have a major responsibility to make the right design decisions. Programmes to target priority health problems through primary care need to be complemented by public-health interventions at national or international level. These may offer scale efficiencies; for some problems, they may be the only workable option. The evidence is overwhelming that action on that scale, for selected interventions, which may range from public hygiene and disease prevention to health promotion, can have a major contribution to health. Yet, they are surprisingly neglected, across all countries, regardless of income level. This is particularly visible at moments of crisis and acute threats to the public’s health, when rapid response capacity is essential not only to secure health, but also to maintain the public trust in the health system.

Public policy-making, however, is about more than classical public health. Primary care and social protection reforms critically depend on choosing health-systems policies, such as those related to essential drugs, technology, human resources and financing, which are supportive of the reforms that promote equity and people-centred care. Furthermore, it is clear that population health can be improved through policies that are controlled by sectors other than health. School curricula, the industry’s policy towards gender equality, the safety of food and consumer goods, or the transport of toxic waste are all issues that can profoundly influence or even determine the health of entire communities, positively or negatively, depending on what choices are made. With deliberate efforts towards intersectoral collaboration, it is possible to give due consideration to “health in all policies”\textsuperscript{29} to ensure that, along with the other sectors’ goals and objectives, health effects play a role in public policy decisions.

In order to bring about such reforms in the extraordinarily complex environment of the health sector, it will be necessary to reinvest in public leadership in a way that pursues collaborative models of policy dialogue with multiple stakeholders – because this is what people expect, and because this is what works best. Health authorities can do a much better job of formulating and implementing PHC reforms adapted to specific national contexts and constraints if the mobilization around PHC is informed by the lessons of past successes and failures. The governance of health is a major challenge for ministries of health and the other institutions, governmental and nongovernmental, that provide health leadership. They can no longer be content with mere administration of the system: they have to become learning organizations. This requires inclusive leadership that engages with a variety of stakeholders beyond the boundaries of the public sector, from clinicians to civil society, and from communities to researchers and academia. Strategic areas for investment to improve the capacity of health authorities to lead PHC reforms include making health information systems instrumental to reform; harnessing the innovations in the health sector and the related dynamics in all societies; and building capacity through exchange and exposure to the experience of others – within and across borders.

**Seizing opportunities**

These four sets of PHC reforms are driven by shared values that enjoy large support and challenges that are common to a globalizing world. Yet, the starkly different realities faced by individual countries must inform the way they are taken forward. The operationalization of universal coverage, service delivery, public policy and leadership reforms cannot be implemented as a blueprint or as a standardized package.

In high-expenditure health economies, which is the case of most high-income countries, there is ample financial room to accelerate the shift from tertiary to primary care, create a healthier policy environment and complement a well-established
universal coverage system with targeted measures to reduce exclusion. In the large number of fast-growing health economies – which is where 3 billion people live – that very growth provides opportunities to base health systems on sound primary care and universal coverage principles at a stage where it is in full expansion, avoiding the errors by omission, such as failing to invest in healthy public policies, and by commission, such as investing disproportionately in tertiary care, that have characterized health systems in high-income countries in the recent past. The challenge is, admittedly, more daunting for the 2 billion people living in the low-growth health economies of Africa and South-East Asia, as well as for the more than 500 million who live in fragile states. Yet, even here, there are signs of growth – and evidence of a potential to accelerate it through other means than through the counter-productive reliance on inequitable out-of-pocket payments at points of delivery – that offer possibilities to expand health systems and services. Indeed, more than in other countries, they cannot afford not to opt for PHC and, as elsewhere, they can start doing so right away.

The current international environment is favourable to a renewal of PHC. Global health is receiving unprecedented attention, with growing interest in united action, greater calls for comprehensive and universal care – be it from people living with HIV and those concerned with providing treatment and care, ministers of health, or the Group of Eight (G8) – and a mushrooming of innovative global funding mechanisms related to global solidarity. There are clear and welcome signs of a desire to work together in building sustainable systems for health rather than relying on fragmented and piecemeal approaches.

At the same time, there is a perspective of enhanced domestic investment in re-invigorating the health systems around PHC values. The growth in GDP – admittedly vulnerable to economic slowdown, food and energy crises and global warming – is fuelling health spending throughout the world, with the notable exception of fragile states. Harnessing this economic growth would offer opportunities to effectuate necessary PHC reforms that were unavailable during the 1980s and 1990s. Only a fraction of health spending currently goes to correcting common distortions in the way health systems function or to overcoming system bottlenecks that constrain service delivery, but the potential is there and is growing fast.

Global solidarity – and aid – will remain important to supplement and support countries making slow progress, but it will become less important per se than exchange, joint learning and global governance. This transition has already taken place in most of the world: most developing countries are not aid-dependent. International cooperation can accelerate the conversion of the world’s health systems, including through better channelling of aid, but real progress will come from better health governance in countries – low- and high-income alike.

The health authorities and political leaders are ill at ease with current trends in the development of health systems and with the obvious need to adapt to the changing health challenges, demands and rising expectations. This is shaping the current opportunity to implement PHC reforms. People’s frustration and pressure for different, more equitable health care and for better health protection for society is building up: never before have expectations been so high about what health authorities and, specifically, ministries of health should be doing about this.

By capitalizing on this momentum, investment in PHC reforms can accelerate the transformation of health systems so as to yield better and more equitably distributed health outcomes. The world has better technology and better information to allow it to maximize the return on transforming the functioning of health systems. Growing civil society involvement in health and scale-efficient collective global thinking (for example, in essential drugs) further contributes to the chances of success.

During the last decade, the global community started to deal with poverty and inequality across the world in a much more systematic way – by setting the MDGs and bringing the issue of inequality to the core of social policy-making. Throughout, health has been a central, closely interlinked concern. This offers opportunities for more effective health action. It also creates the necessary social conditions for the establishment of close alliances beyond the health sector. Thus,
intersectoral action is back on centre stage. Many among today’s health authorities no longer see their responsibility for health as being limited to survival and disease control, but as one of the key capabilities people and societies value. The legitimacy of health authorities increasingly depends on how well they assume responsibility to develop and reform the health sector according to what people value – in terms of health and of what is expected of health systems in society.

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The challenges of a changing world

This chapter describes the context in which the contemporary renewal of primary health care is unfolding. The chapter reviews current challenges to health and health systems and describes a set of broadly shared social expectations that set the agenda for health systems change in today’s world. It shows how many countries have registered significant health progress over recent decades and how gains have been unevenly shared. Health gaps between countries and among social groups within countries have widened. Social, demographic and epidemiological transformations fed by globalization, urbanization and ageing populations, pose challenges of a magnitude that was not anticipated three decades ago.
The chapter argues that, in general, the response of the health sector and societies to these challenges has been slow and inadequate. This reflects both an inability to mobilize the requisite resources and institutions to transform health around the values of primary health care as well as a failure to either counter or substantially modify forces that pull the health sector in other directions, namely: a disproportionate focus on specialist hospital care; fragmentation of health systems; and the proliferation of unregulated commercial care. Ironically, these powerful trends lead health systems away from what people expect from health and health care. When the Declaration of Alma-Ata enshrined the principles of health equity, people-centred care and a central role for communities in health action, they were considered radical. Social research suggests, however, that these values are becoming mainstream in modernizing societies: they correspond to the way people look at health and what they expect from their health systems. Rising social expectations regarding health and health care, therefore, must be seen as a major driver of PHC reforms.

**Unequal growth, unequal outcomes**

**Longer lives and better health, but not everywhere**

In the late 1970s, the Sultanate of Oman had only a handful of health professionals. People had to travel up to four days just to reach a hospital, where hundreds of patients would already be waiting in line to see one of the few (expatriate) doctors. All this changed in less than a generation. Oman invested consistently in a national health service and sustained that investment over time. There is now a dense network of 180 local, district and regional health facilities staffed by over 5000 health workers providing almost universal access to health care for Oman’s 2.2 million citizens, with coverage now being extended to foreign residents. Over 98% of births in Oman are now attended by trained personnel and over 98% of infants are fully immunized. Life expectancy at birth, which was less than 60 years towards the end of the 1970s, now surpasses 74 years.

The under-five mortality rate has dropped by a staggering 94%.

In each region (except in the African region) there are countries where mortality rates are now less than one fifth of what they were 30 years ago. Leading examples are Chile, Malaysia, Portugal and Thailand (Figure 1.1). These results were associated with improved access to expanded health-care networks, made possible by sustained political commitment and by economic growth that allowed them to back up their commitment by maintaining investment in the health sector (Box 1.1).

![Figure 1.1 Selected best performing countries in reducing under-five mortality by at least 80%, by regions, 1975–2006](image)

Overall, progress in the world has been considerable. If children were still dying at 1978 rates, there would have been 16.2 million deaths globally in 2006. In fact, there were only 9.5 million such deaths. This difference of 6.7 million is equivalent to 18 329 children’s lives being saved every day.

But these figures mask significant variations across countries. Since 1975, the rate of decline in under-five mortality rates has been much slower in low-income countries as a whole than in the richer countries. Apart from Eritrea and Mongolia, none of today’s low-income countries has reduced under-five mortality by as much as 70%. The countries that make up today’s middle-income countries have done better, but, as Figure 1.3 illustrates, progress has been quite uneven.
Box 1.1 Economic development and investment choices in health care: the improvement of key health indicators in Portugal

Portugal recognized the right to health in its 1976 Constitution, following its democratic revolution. Political pressure to reduce large health inequalities within the country led to the creation of a national health system, funded by taxation and complemented by public and private insurance schemes and out-of-pocket payments. The system was fully established between 1979 and 1983 and explicitly organized around PHC principles: a network of health centres staffed by family physicians and nurses progressively covered the entire country. Eligibility for benefits under the national health system requires patients to register with a family physician in a health centre as the first point of contact. Portugal considers this network to be its greatest success in terms of improved access to care and health gains.

Life expectancy at birth is now 9.2 years more than it was 30 years ago, while the GDP per capita has doubled. Portugal’s performance in reducing mortality in various age groups has been among the world’s most consistently successful over the last 30 years, for example halving infant mortality rates every eight years. This performance has led to a marked convergence of the health of Portugal’s population with that of other countries in the region.

Multivariate analysis of the time series of the various mortality indices since 1960 shows that the decision to base Portugal’s health policy on PHC principles, with the development of a network of comprehensive primary care services, has played a major role in the reduction of maternal and child mortality, whereas the reduction of perinatal mortality was linked to the development of the hospital network. The relative roles of the development of primary care, hospital networks and economic growth to the improvement of mortality indices since 1960 are shown in Figure 1.2.

Some countries have made great improvements and are on track to achieve the health-related MDGs. Others, particularly in the African region, have stagnated or even lost ground. Globally, 20 of the 25 countries where under-five mortality is still two thirds or more of the 1975 level are in sub-Saharan Africa. Slow progress has been associated with disappointing advances in access to health care. Despite recent change for the better, vaccination coverage in sub-Saharan Africa is still significantly lower than in the rest of the world. Current contraceptive prevalence remains as low as 21%, while in other developing regions increases have been substantial over the past 30 years and now reach 61%, . Increased contraceptive use has been accompanied by decreased abortion rates everywhere. In sub-Saharan Africa, however, the absolute numbers of abortions has increased, and almost all are being performed in unsafe conditions. Childbirth care for mothers and newborns also continues to face problems: in 33 countries, less than half of all births each year are attended by skilled health personnel, with coverage in one country as low as 6%.

Sub-Saharan Africa is also the only region

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Figure 1.2 Factors explaining mortality reduction in Portugal, 1960–2008

- Relative weight of factors (%)
  - Growth in GDP per capita (constant prices)
  - Development of primary care networks (primary care physicians and nurses per inhabitant)
  - Development of hospital networks (hospital physicians and nurses per inhabitant)

Figure 1.3 Variable progress in reducing under-five mortality, 1975 and 2006, in selected countries with similar rates in 1975

Deaths per 1000 children under five

- Oman (THE 2006: IS 382)
- Mongolia (THE 2006: IS 149)
- Morocco (THE 2006: IS 273)
- Tajikistan (THE 2006: IS 71)
- India (THE 2006: IS 193)
- Madagascar (THE 2006: IS 59)
- Zambia (THE 2006: IS 62)

a Total health expenditure per capita 2006, international $.
in the world where access to qualified providers at childbirth is not progressing. Mirroring the overall trends in child survival, global trends in life expectancy point to a rise throughout the world of almost eight years between 1950 and 1978, and seven more years since: a reflection of the growth in average income per capita. As with child survival, widening income inequality (income increases faster in high-income than in low-income countries) is reflected in increasing disparities between the least and most healthy. Between the mid-1970s and 2005, the difference in life expectancy between high-income countries and countries in sub-Saharan Africa, or fragile states, has widened by 3.8 and 2.1 years, respectively.

The unmistakable relation between health and wealth, summarized in the classic Preston curve, needs to be qualified. Firstly, the Preston curve continues to shift. An income per capita of 1,000 in 1975 was associated with a life expectancy of 48.8 years. In 2005, it was almost four years higher for the same income. This suggests that improvements in nutrition, education, health technologies, the institutional capacity to obtain and use information, and in society’s ability to translate this knowledge into effective health and social action, allow for greater production of health for the same level of wealth.

Secondly, there is considerable variation in achievement across countries with the same income, particularly among poorer countries. For example, life expectancy in Côte d’Ivoire (GDP $1465) is nearly 17 years lower than in Nepal (GDP $1379), and between Madagascar and Zambia, the difference is 18 years. The presence of high performers in each income band shows that the actual level of income per capita at a given moment is not the absolute rate limiting factor the average curve seems to imply.

Growth and stagnation

Over the last 30 years the relation between economic growth and life expectancy at birth has shown three distinct patterns (Figure 1.5).

In 1978, about two thirds of the world’s population lived in countries that went on to experience increases in life expectancy at birth and considerable economic growth. The most impressive relative gains were in a number of low-income countries in Asia (including India), Latin America and northern Africa, totalling 1.1 billion inhabitants 30 years ago and nearly 2 billion today. These countries increased life expectancy at birth by 12 years, while GDP per capita was multiplied by a factor of 2.6. High-income countries and countries with a GDP between $3000 and $10,000 in 1975 also saw substantial economic growth and increased life expectancy.

In other parts of the world, GDP growth was not accompanied by similar gains in life expectancy. The Russian Federation and Newly Independent States increased average GDP per capita substantially, but, with the widespread poverty that accompanied the transition from the former Soviet Union, women’s life expectancy stagnated from the late 1980s and men’s plummeted, particularly for those lacking education and job security. After a period of technological and organizational stagnation, the health system collapsed. Public expenditure on health declined in the 1990s to levels that made running a basic system virtually impossible in several countries. Unhealthy lifestyles, combined with the disintegration of public health programmes, and the unregulated commercialization of clinical services combined with the elimination of safety nets has offset any gains from the increase in average GDP. China had already increased its
Chapter 1. The challenges of a changing world

Life expectancy substantially in the period before 1980 to levels far above that of other low-income countries in the 1970s, despite the 1961–1963 famine and the 1966–1976 Cultural Revolution. The contribution of rural primary care and urban health insurance to this has been well documented.27,28 With the economic reforms of the early 1980s, however, average GDP per capita increased spectacularly, but access to care and social protection deteriorated, particularly in rural areas. This slowed down improvements to a modest rate, suggesting that only the improved living conditions associated with the spectacular economic growth avoided a regression of average life expectancy.29

Finally, there is a set of low-income countries, representing roughly 10% of the world’s population, where both GDP and life expectancy stagnated.30 These are the countries that are considered as “fragile states” according to the “low-income countries under stress” (LICUS) criteria for 2003–2006.31 As much as 66% of the population in these countries is in Africa. Poor governance and extended internal conflicts are common among these countries, which all face similar hurdles: weak security, fractured societal relations, corruption, breakdown in the rule of law, and lack of mechanisms for generating legitimate power and authority.32 They have a huge backlog of investment needs and limited government resources to meet them. Half of them experienced negative GDP growth during the period 1995–2004 (all the others remained below the average growth of low-income countries), while their external debt was above average.33 These countries were among those with the lowest life expectancy at birth in 1975 and have experienced minimal increases since then. The other low-income African countries share many of the characteristics and circumstances of the fragile states – in fact many of them have suffered protracted periods of conflict over the last 30 years that would have classified them as fragile states had the LICUS classification existed at that time. Their economic growth has been very limited, as has been their life-expectancy gain, not least because of the presence, in this group, of a number of southern African countries that are disproportionally confronted by the HIV/AIDS pandemic. On average, the latter have seen some economic growth since 1975, but a marked reversal in terms of life expectancy.

What has been strikingly common to fragile states and sub-Saharan African countries for
much of the last three decades, and differentiates them from the others that started out with less than IS 3000 per capita in 1975, is the combination of stagnating economic growth, political instability and lack of progress in life expectancy. They accumulate characteristics that hamper improvement of health. Education, particularly of females, develops more slowly, as does access to modern communications and knowledge-intensive work that broadens people’s intellectual resources elsewhere. People are more exposed and more vulnerable to environmental and other health threats that, in today’s globalized world, include lifestyle threats, such as smoking, obesity and urban violence. They lack the material security required to invest in their own health and their governments lack the necessary resources and/or commitment to public investment. They are at much greater risk of war and civil conflict than richer countries.

Without growth, peace is considerably more difficult and without peace, growth stagnates: on average, a civil war reduces a country’s growth by around 2.3% per year for a typical duration of seven years, leaving it 15% poorer.

The impact of the combination of stagnation and conflicts cannot be overstated. Conflicts are a direct source of considerable excessive suffering, disease and mortality. In the Democratic Republic of the Congo, for example, the 1998–2004 conflict caused an excess mortality of 450,000 deaths per year. Any strategy to close the health gaps between countries – and to correct inequalities within countries – has to give consideration to the creation of an environment of peace, stability and prosperity that allows for investment in the health sector.

A history of poor economic growth is also a history of stagnating resources for health. What

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**Box 1.2 Higher spending on health is associated with better outcomes, but with large differences between countries**

In many countries, the total amount spent on health is insufficient to finance access for all to even a very limited package of essential health care. This is bound to make a difference to health and survival. Figure 1.6 shows that Kenya has a health-adjusted life expectancy (HALE) of 44.4 years, the median for countries that currently spend less than IS 100 per capita on health. This is 27 years less than Germany, the median for countries that spend more than IS 2500 per capita. Every IS 100 per capita spent on health corresponds to a 1.1-year gain in HALE. However, this masks large differences in outcomes at comparable levels of spending. There are up to five years difference in HALE between countries that spend more than IS 2500 per capita per year on health. The spread is wider at lower expenditure levels, even within rather narrow spending bands. Inhabitants of Moldova, for example, enjoy 24 more HALE years than those of Haiti, yet they are both among the 28 countries that spend IS 250–500 per capita on health. These gaps can even be wider if one also considers countries that are heavily affected by HIV/AIDS. Lesotho spends more on health than Jamaica, yet its people have a HALE that is 34 years shorter. In contrast, the differences in HALE between the countries with the best outcomes in each spending band are comparatively small. Tajikistan, for example, has a HALE that is 4.3 years less than that of Sweden – less than the difference between Sweden and the United States. These differences suggest that how, for what and for whom money is spent matters considerably. Particularly in countries where the envelope for health is very small, every dollar that is allocated sub-optimally seems to make a disproportionate difference.

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**Figure 1.6 Countries grouped according to their total health expenditure in 2005 (international $)**

<table>
<thead>
<tr>
<th>Total health expenditure (no. of countries)</th>
<th>HALE (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE &lt; IS 100 (35)</td>
<td>20–40</td>
</tr>
<tr>
<td>THE IS 100–250 (28)</td>
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<tr>
<td>THE IS 250–500 (30)</td>
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<td>THE IS 500–1000 (23)</td>
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<td>THE IS 1000–2500 (16)</td>
<td>80–90</td>
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<td>THE IS &gt; IS 2500 (15)</td>
<td>Highest</td>
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*Box 1.2 Higher spending on health is associated with better outcomes, but with large differences between countries.*

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happened in sub-Saharan Africa during the years following Alma-Ata exemplifies this predicament. After adjusting for inflation, GDP per capita in sub-Saharan Africa fell in most years from 1980–1994, leaving little room to expand access to health care or transform health systems. By the early 1980s, for example, the medicines budget in the Democratic Republic of the Congo, then Zaïre, was reduced to zero and government disbursements to health districts dropped below US$ 0.1 per inhabitant; Zambia’s public sector health budget was cut by two thirds; and funds available for operating expenses and salaries for the expanding government workforce dropped by up to 70% in countries such as Cameroon, Ghana, Sudan and the United Republic of Tanzania. For health authorities in this part of the world, the 1980s and 1990s were a time of managing shrinking government budgets and disinvestment. For the people, this period of fiscal contraction was a time of crippling out-of-pocket payments for under-funded and inadequate health services.

In much of the world, the health sector is often massively under-funded. In 2005, 45 countries spent less than IS 100 per capita on health, including external assistance. In contrast, 16 high-income countries spent more than IS 3000 per capita. Low-income countries generally allocate a smaller proportion of their GDP to health than high-income countries, while their GDP is smaller to start with and they have higher disease burdens.

Higher health expenditure is associated with better health outcomes, but sensitive to policy choices and context (Box 1.2): where money is scarce, the effects of errors, by omission and by commission, are amplified. Where expenditure increases rapidly, however, this offers perspectives for transforming and adapting health systems which are much more limited in a context of stagnation.

**Adapting to new health challenges**

**A globalized, urbanized and ageing world**

The world has changed over the last 30 years: few would have imagined that children in Africa would now be at far more risk of dying from traffic accidents than in either the high- or the low- and middle-income countries of the European region (Figure 1.7). Many of the changes that affect health were already under way in 1978, but they have accelerated and will continue to do so.

Thirty years ago, some 38% of the world’s population lived in cities; in 2008, it is more than 50%, 3.3 billion people. By 2030, almost 5 billion people will live in urban areas. Most of the growth will be in the smaller cities of developing countries and metropolises of unprecedented size and complexity in southern and eastern Asia.

Although on average health indicators in cities score better than in rural areas, the enormous social and economic stratification within urban areas results in significant health inequities. In the high-income area of Nairobi, the under-five mortality rate is below 15 per thousand, but in the Emabakasi slum of the same city the rate is 254 per thousand. These and other similar examples lead to the more general observation that within developing countries, the best local governance can help produce 75 years or more of life expectancy; with poor urban governance, life expectancy can be as low as 35 years. One third of the urban population today – over one billion people – lives in slums: in places that lack durable housing, sufficient living area, access to clean water and sanitation, and secure tenure. Slums are prone to fire, floods and landslides; their inhabitants are disproportionately exposed to pollution, accidents, workplace hazards and urban violence. Loss of social
cohesion and globalization of unhealthy lifestyles contribute to an environment that is decidedly unfavourable for health.

These cities are where many of the world’s nearly 200 million international migrants are found. They constitute at least 20% of the population in 41 countries, 31% of which have less than a million inhabitants. Excluding migrants from access to care is the equivalent of denying all the inhabitants of a country similar to Brazil their rights to health. Some of the countries that have made very significant strides towards ensuring access to care for their citizens fail to offer the same rights to other residents. As migration continues to gain momentum, the entitlements of non-citizen residents and the ability of the healthcare system to deal with growing linguistic and cultural diversity in equitable and effective ways are no longer marginal issues.

This mobile and urbanized world is ageing fast and will continue to do so. By 2050, the world will count 2 billion people over the age of 60, around 85% of whom will be living in today’s developing countries, mostly in urban areas. Contrary to today’s rich countries, low- and middle-income countries are ageing fast before having become rich, adding to the challenge.

Urbanization, ageing and globalized lifestyle changes combine to make chronic and noncommunicable diseases – including depression, diabetes, cardiovascular disease and cancers – and injuries increasingly important causes of morbidity and mortality (Figure 1.8). There is a striking shift in distribution of death and disease from younger to older ages and from infectious, perinatal and maternal causes to noncommunicable diseases. Traffic accident rates will increase; tobacco-related deaths will overtake HIV/AIDS-related deaths. Even in Africa, where the population remains younger, smoking, elevated blood pressure and cholesterol are among the top 10 risk factors in terms of overall disease burden. In the last few decades, much of the lack of progress and virtually all reversals in life expectancy were associated with adult health crises, such as in the Russian Federation or southern Africa. Improved health in the future will increasingly be a question of better adult health.

Ageing has drawn attention to an issue that is of particular relevance to the organization of service delivery: the increasing frequency of multi-morbidity. In the industrialized world, as many as 25% of 65–69 year olds and 50% of 80–84 year olds are affected by two or more chronic health conditions simultaneously. In socially deprived populations, children and younger adults are also likely to be affected. The frequency of multi-morbidity in low-income countries is less well described except in the context of the HIV/AIDS epidemic, malnutrition or malaria, but it is probably greatly underestimated. As diseases of poverty are inter-related, sharing causes that

Figure 1.8 The shift towards noncommunicable diseases and accidents as causes of death*

Deaths (millions)

* Selected causes.
are multiple and act together to produce greater disability and ill health, multi-morbidity is probably more rather than less frequent in poor countries. Addressing co-morbidity – including mental health problems, addictions and violence – emphasizes the importance of dealing with the person as a whole. This is as important in developing countries as in the industrialized world.  

It is insufficiently appreciated that the shift to chronic diseases or adult health has to come on top of an unfinished agenda related to communicable diseases, and maternal, newborn and child health. Efforts directed at the latter, especially in the poorest countries where coverage is still insufficient, will have to expand. But all health systems, including those in the poorest countries, will also have to deal with the expanding need and demand for care for chronic and noncommunicable diseases: this is not possible without much more attention being paid to establishing a continuum of comprehensive care than is the case today. It is equally impossible without much more attention being paid to addressing the pervasive health inequalities within each country (Box 1.3).

**Little anticipation and slow reactions**

Over the past few decades, health authorities have shown little evidence of their ability to anticipate such changes, prepare for them or even adapt to them when they have become an everyday reality. This is worrying because the rate of change is accelerating. Globalization, urbanization and ageing will be compounded by the health effects of other global phenomena, such as climate change, the impact of which is expected to be greatest among the most vulnerable communities living in the poorest countries. Precisely how these will affect health in the coming years is more difficult to predict, but rapid changes in disease burden, growing health inequalities and disruption of social cohesion and health sector resilience are to be expected. The current food crisis has shown how unprepared health authorities often are for changes in the broader environment, even after other sectors have been sounding the alarm bell for quite some time. All too often, the accelerated pace and the global scale of the changes in the challenges to health is in contrast with the sluggish response of national health systems.  

Even for well-known and documented trends, such as those resulting from the demographic and epidemiologic transitions, the level of response often remains inadequate. Data from WHO’s World Health Surveys, covering 18 low-income countries, show low coverage of the treatment of asthma, arthritis, angina, diabetes and depression, and of the screening for cervical and breast cancer: less than 15% in the lowest income quintile and less than 25% in the highest. Public-health interventions to remove the major risk factors of disease are often neglected, even when they are particularly cost effective: they have the potential to reduce premature deaths by 47% and increase global healthy life expectancy by 9.3 years. For example, premature tobacco-attributable deaths from ischaemic heart disease, cerebrovascular disease, chronic obstructive pulmonary disease and other diseases are projected to rise from 5.4 million in 2004 to 8.3 million in 2030, almost 10% of all deaths worldwide, with more than 80% in developing countries. Yet, two out of every three countries are still without, or only have minimal, tobacco control policies.  

With a few exceptions – the SARS epidemic, for example – the health sector has often been slow in dealing with new or previously underestimated health challenges. For example, awareness of the emerging health threats posed by climate change and environmental hazards dates back at least to the 1990 Earth Summit, but only in recent years have these begun to be translated into plans and strategies. Health authorities have also often failed to assess, in a timely way, the significance of changes in their political environment that affect the sector’s response capacity. Global and national policy environments have often taken health issues into consideration, initiating hasty and disruptive interventions, such as structural adjustment, decentralization, blueprint poverty reduction strategies, insensitive trade policies, new tax regimes, fiscal policies and the withdrawal of the state. Health authorities have a poor track record in influencing such developments, and have been ineffective in leveraging the economic weight of the health sector. Many of the critical systems issues affecting health require skills and competencies that are not found within the medical/public health establishment. The failure
Box 1.3 As information improves, the multiple dimensions of growing health inequality are becoming more apparent

In recent years, the extent of within-country disparities in vulnerability, access to care and health outcomes has been described in much greater detail (Figure 1.9)\(^6\). Better information shows that health inequalities tend to increase, thereby highlighting how inadequate and uneven health systems have been in responding to people’s health needs. Despite the recent emphasis on poverty reduction, health systems continue to have difficulty in reaching both the rural and the urban poor, let alone addressing the multiple causes and consequences of health inequity.

Figure 1.9 Within-country inequalities in health and health care
Trends that undermine the health systems’ response

Without strong policies and leadership, health systems do not spontaneously gravitate towards PHC values or efficiently respond to evolving health challenges. As most health leaders know, health systems are subject to powerful forces and influences that often override rational priority setting or policy formation, thereby pulling health systems away from their intended directions. Characteristic trends that shape conventional health systems today include (Figure 1.10):

- a disproportionate focus on specialist, tertiary care, often referred to as “hospital-centrism”;
- fragmentation, as a result of the multiplication of programmes and projects; and
- the pervasive commercialization of health care in unregulated health systems.

With their focus on cost containment and deregulation, many of the health-sector reforms of the 1980s and 1990s have reinforced these trends. High-income countries have often been able to regulate to contain some of the adverse consequences of these trends. However, in countries where under-funding compounds limited regulatory capacity, they have had more damaging effects.

Hospital-centrism: health systems built around hospitals and specialists

For much of the 20th century, hospitals, with their technology and sub-specialists, have gained a pivotal role in most health systems throughout the world. Today, the disproportionate focus on hospitals and sub-specialization has become a major source of inefficiency and inequality, and one that has proved remarkably resilient. Health authorities may voice their concern more insistently than they used to, but sub-specialization continues to prevail. For example, in Member countries of the Organisation of Economic Co-operation and Development (OECD), the 35% growth in the number of doctors in the last 15 years was driven by rising numbers of specialists (up by nearly 50% between 1990 and 2005 – compared with only a 20% increase in general practitioners). In Thailand, less than 20% of doctors were specialists 30 years ago; by 2003 they represented 70%.

The forces driving this growth include professional traditions and interests as well as the considerable economic weight of the health industry – technology and pharmaceuticals (Box 1.4). Obviously, well functioning specialized tertiary care responds to a real demand (albeit, at least in part, induced): it is necessary, at the very least, for the political credibility of the health system. However, the experience of industrialized countries has shown that a disproportionate focus on specialist, tertiary care provides poor value for money. Hospital-centrism carries a considerable cost in terms of unnecessary medicalization and iatrogenesis, and compromises the human and social dimensions of health. It also carries an opportunity cost: Lebanon, for example, counts more cardiac surgery units per inhabitant than Germany, but lacks programmes aimed at reducing the risk factors for cardiovascular disease. Inefficient ways of dealing with health problems are thus crowding out more effective, efficient – and more equitable – ways of organizing health care and improving health.

Since the 1980s, a majority of OECD countries has been trying to decrease reliance on hospitals,
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Box 1.4 Medical equipment and pharmaceutical industries are major economic forces

Global expenditure on medical equipment and devices has grown from US$ 145 billion in 1998 to US$ 220 billion in 2006: the United States accounts for 39% of the total, the European Union for 27%, and Japan for 16%81. The industry employs more than 411,000 workers in the United States alone, occupying nearly one third of the country’s bioscience jobs87. In 2006, the United States, the European Union and Japan spent US$ 287, US$ 250 and US$ 273 per capita, respectively, on medical equipment. In the rest of the world, the average of such expenditure is in the order of US$ 6 per capita, and in sub-Saharan Africa – a market with much potential for expansion – it is US$ 2.5 per capita. The annual growth rate of the equipment market is over 10% a year82.

The pharmaceutical industry weighs even more heavily in the global economy, with global pharmaceutical sales expected to expand to US$ 735–745 billion in 2008, with a growth rate of 6–7%83. Here, too, the United States is the world’s largest market, accounting for around 48% of the world total: per capita expenditure on drugs was US$ 1141 in 2005, twice the level of Canada, Germany or the United Kingdom, and 10 times that of Mexico84.

Specialized and hospital care is vital to these industries, which depend on pre-payment and risk pooling for sustainable funding of their expansion. While this market grows everywhere, there are large differences from country to country. For example, Japan and the United States have 5–8 times more magnetic resonance imaging (MRI) units per million inhabitants than Canada and the European Union. For computerized tomography (CT) scanners, the differences are even more pronounced: Japan had 92.6 per million in 2002, the Netherlands 5.8 in 200585. These differences show that the market can be influenced, principally by using appropriate payment and reimbursement incentives and by careful consideration of the organization of regulatory control86.

Specialists and technologies, and keep costs under control. They have done this by introducing supply-side measures including reduction of hospital beds, substitution of hospitalization by home care, rationing of medical equipment, and a multitude of financial incentives and disincentives to promote micro-level efficiency. The results of these efforts have been mixed, but the evolving technology is accelerating the shift from specialized hospital to primary care. In many high-income countries (but not all), the PHC efforts of the 1980s and 1990s have been able to reach a better balance between specialized curative care, first contact care and health promotion87. Over the last 30 years, this has contributed to significant improvements in health outcomes81,82. More recently, middle-income countries, such as Chile with its Atención Primaria de Salud (Primary Health Care)83, Brazil with its family health initiative and Thailand under its universal coverage scheme84 have shifted the balance between specialized hospital and primary care in the same way85. The initial results are encouraging: improvement of outcome indicators86 combined with a marked improvement in patient satisfaction87. In each of these cases, the shift took place as part of a move towards universal coverage, with expanded citizen’s rights to access and social protection. These processes are very similar to what occurred in Malaysia and Portugal: right to access, social protection, and a better balance between reliance on hospitals and on generalist primary care, including prevention and health promotion88.

Industrialized countries are, 50 years later, trying to reduce their reliance on hospitals, having realized the opportunity cost of hospital-centrism in terms of effectiveness and equity. Yet, many low- and middle-income countries are creating the same distortions. The pressure from consumer demand, the medical professions and the medico-industrial complex88 is such that private and public health resources flow disproportionately towards specialized hospital care at the expense of investment in primary care. National health authorities have often lacked the financial and political clout to curb this trend and achieve a better balance. Donors have also used their influence more towards setting up disease control programmes than towards reforms that would make primary care the hub of the health system89.

Fragmentation: health systems built around priority programmes

While urban health by and large revolves around hospitals, the rural poor are increasingly confronted with the progressive fragmentation of their health services, as “selective” or “vertical” approaches focus on individual disease control programmes and projects. Originally considered
as an interim strategy to achieve equitable health outcomes, they sprang from a concern for the slow expansion of access to health care in a context of persistent severe excess mortality and morbidity for which cost-effective interventions exist\(^97\). A focus on programmes and projects is particularly attractive to an international community concerned with getting a visible return on investment. It is well adapted to command-and-control management: a way of working that also appeals to traditional ministries of health. With little tradition of collaboration with other stakeholders and participation of the public, and with poor capacity for regulation, programmatic approaches have been a natural channel for developing governmental action in severely resource-constrained and donor-dependent countries. They have had the merit of focusing on health care in severely resource-constrained circumstances, with welcome attention to reaching the poorest and those most deprived of services.

Many have hoped that single-disease control initiatives would maximize return on investment and somehow strengthen health systems as interventions were delivered to large numbers of people, or would be the entry point to start building health systems where none existed. Often the opposite has proved true. The limited sustainability of a narrow focus on disease control, and the distortions it causes in weak and under-funded health systems have been criticized extensively in recent years\(^98\). Short-term advances have been short-lived and have fragmented health services to a degree that is now of major concern to health authorities. With parallel chains of command and funding mechanisms, duplicated supervision and training schemes, and multiplied transaction costs, they have led to situations where programmes compete for scarce resources, staff and donor attention, while the structural problems of health systems – funding, payment and human resources – are hardly addressed. The discrepancy in salaries between regular public sector jobs and better-funded programmes and projects has exacerbated the human resource crisis in fragile health systems. In Ethiopia, contract staff hired to help implement programmes were paid three times more than regular government employees\(^99\), while in Malawi, a hospital saw 88 nurses leave for better paid nongovernmental organization (NGO) programmes in an 18-month period\(^100\).

Eventually, service delivery ends up dealing only with the diseases for which a (funded) programme exists – overlooking people who have the misfortune not to fit in with current programme priorities. It is difficult to maintain the people’s trust if they are considered as mere programme targets: services then lack social sustainability. This is not just a problem for the population. It puts health workers in the unenviable position of having to turn down people with “the wrong kind of problem” – something that fits ill with the self-image of professionalism and caring many cherish. Health authorities may at first be seduced by the straightforwardness of programme funding and management, yet once programmes multiply and fragmentation becomes unmanageable and unsustainable, the merits of more integrated approaches are much more evident. The re-integration of programmes once they have been well established is no easy task.

**Health systems left to drift towards unregulated commercialization**

In many, if not most low- and middle-income countries, under-resourcing and fragmentation of health services has accelerated the development of commercialized health care, defined here as the unregulated fee-for-service sale of health care, regardless of whether or not it is supplied by public, private or NGO providers.

Commercialization of health care has reached previously unheard of proportions in countries that, by choice or due to a lack of capacity, fail to regulate the health sector. Originally limited to an urban phenomenon, small-scale unregulated fee-for-service health care offered by a multitude of different independent providers now dominates the health-care landscape from sub-Saharan Africa to the transitional economies in Asia or Europe.

Commercialization often cuts across the public-private divide\(^101\). Health-care delivery in many governmental and even in traditionally not-for-profit NGO facilities has been de facto commercialized, as informal payment systems and cost-recovery systems have shifted the cost of services to users in an attempt to compensate
for the chronic under-funding of the public health sector and the fiscal stringency of structural adjustment\textsuperscript{102,103}. In these same countries, moonlighting civil servants make up a considerable part of the unregulated commercial sector\textsuperscript{104}, while others resort to under-the-counter payments\textsuperscript{105,106,107}. The public-private debate of the last decades has, thus, largely missed the point: for the people, the real issue is not whether their health-care provider is a public employee or a private entrepreneur, nor whether health facilities are publicly or privately owned. Rather, it is whether or not health services are reduced to a commodity that can be bought and sold on a fee-for-service basis without regulation or consumer protection\textsuperscript{108}.

Commercialization has consequences for quality as well as for access to care. The reasons are straightforward: the provider has the knowledge; the patient has little or none. The provider has an interest in selling what is most profitable, but not necessarily what is best for the patient. Without effective systems of checks and balances, the results can be read in consumer organization reports or newspaper articles that express outrage at the breach of the implicit contract of trust between caregiver and client\textsuperscript{109}. Those who cannot afford care are excluded; those who can may not get the care they need, often get care they do not need, and invariably pay too much.

Unregulated commercialized health systems are highly inefficient and costly\textsuperscript{110}: they exacerbate inequality\textsuperscript{111}, and they provide poor quality and, at times, dangerous care that is bad for health (in the Democratic Republic of the Congo, for example, “la chirurgie safari” (safari surgery) refers to a common practice of health workers moonlighting by performing appendectomies or other surgical interventions at the patients’ homes, often for crippling fees).

Thus, commercialization of health care is an important contributor to the erosion of trust in health services and in the ability of health authorities to protect the public\textsuperscript{111}. This is what makes it a matter of concern for politicians and, much more than was the case 30 years ago, one of the main reasons for increasing support for reforms that would bring health systems more in line not only with current health challenges, but also with people’s expectations.

### Changing values and rising expectations

The reason why health systems are organized around hospitals or are commercialized is largely because they are supply-driven and also correspond to demand: genuine as well as supply-induced. Health systems are also a reflection of a globalizing consumer culture. Yet, at the same time, there are indications that people are aware that such health systems do not provide an adequate response to need and demand, and that they are driven by interests and goals that are disconnected from people’s expectations. As societies modernize and become more affluent and knowledgeable, what people consider to be desirable ways of living as individuals and as members of societies, i.e. what people value, changes\textsuperscript{112}. People tend to regard health services more as a commodity today, but they also have other, rising expectations regarding health and health care. People care more about health as an integral part of how they and their families go about their everyday lives than is commonly thought (Box 1.5)\textsuperscript{113}. They expect their families and communities to be protected from risks and dangers to health. They want health care that deals with people as individuals with rights and not as mere targets for programmes or beneficiaries of charity. They are willing to respect health professionals but want to be respected in turn, in a climate of mutual trust\textsuperscript{114}.

People also have expectations about the way their society deals with health and health care. They aspire to greater health equity and solidarity and are increasingly intolerant of social exclusion – even if individually they may be reluctant to act on these values\textsuperscript{115}. They expect health authorities – whether in government or other bodies – to do more to protect their right to health. The social values surveys that have been conducted since the 1980s show increasing convergence in this regard between the values of developing countries and of more affluent societies, where protection of health and access to care is often taken for granted\textsuperscript{112,115,116}. Increasing prosperity, access to knowledge and social connectivity are associated with rising expectations. People want to have more say about what happens in their workplace, in the communities in which they live and also in important government decisions that
The desire for better care and protection of health, for less health inequity and for participation in decisions that affect health is more widespread and more intense now than it was 30 years ago. Therefore, much more is expected of health authorities today.

Health equity
Equity, whether in health, wealth or power is rarely, if ever, fully achieved. Some societies are more egalitarian than others, but on the whole the world is “unequal”. Value surveys, however, clearly demonstrate that people care about these inequalities – considering a substantial proportion to be unfair “inequities” that can and should be avoided. Data going back to the early 1980s show that people increasingly disagree with the way in which income is distributed and believe that a “just society” should work to correct these imbalances. This gives policymakers less leeway to ignore the social dimensions of their policies than they might have had previously.

People are often unaware of the full scope of health inequalities. Most Swedish citizens, for example, were probably unaware that the difference in life expectancy between 20-year-old men from the highest and lowest socioeconomic groups was 3.97 years in 1997: a gap that had widened by 88% compared to 1980. However, while people’s knowledge on these topics may be partial, research shows that people regard social gradients in health as profoundly unjust. Intolerance to inequality in health and to the exclusion of population groups from health benefits and social protection mirrors or exceeds intolerance to inequality in income. In most societies, there is wide consensus that everybody should be able to take care of their health and to receive treatment when ill or injured – without being bankrupted and pushed into poverty.

As societies become wealthier, popular support for equitable access to health care and social protection to meet basic health and social needs gains stronger ground. Social surveys show that, in the European region, 93% of the populations support comprehensive health coverage. In the United States, long reputed for its reluctance to adopt a national health insurance system, more than 80% of the population is in favour of it, while basic care for all continues to be widely distributed, intensely known, but extrapolating from their views on income inequality, it is reasonable to assume that increasing prosperity is coupled with rising concern for health equity – even if consensus about how this should be achieved may be as contentious as in richer countries.
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Care that puts people first

People obviously want effective health care when they are sick or injured. They want it to come from providers with the integrity to act in their best interests, equitably and honestly, with knowledge and competence. The demand for competence is not trivial: it fuels the health economy with steadily increased demand for professional care (doctors, nurses and other non-physician clinicians who play an increasing role in both industrialized and developing countries)\(^{129}\). For example, throughout the world, women are switching from the use of traditional birth attendants to midwives, doctors and obstetricians (Figure 1.12)\(^{130}\).

The PHC movement has underestimated the speed with which the transition in demand from traditional caregivers to professional care would bypass initial attempts to rapidly expand access to health care by relying on non-professional “community health workers”, with their added value of cultural competence. Where strategies for extending PHC coverage proposed lay workers as an alternative rather than as a complement to professionals, the care provided has often been perceived to be poor\(^{131}\). This has pushed people towards commercial care, which they, rightly or wrongly, perceived to be more competent, while attention was diverted from the challenge of more effectively incorporating professionals under the umbrella of PHC.

Proponents of PHC were right about the importance of cultural and relational competence, which was to be the key comparative advantage of community health workers. Citizens in the developing world, like those in rich countries, are not looking for technical competence alone: they also want health-care providers to be understanding, respectful and trustworthy\(^{132}\). They want health care to be organized around their needs, respectful of their beliefs and sensitive to their particular situation in life. They do not want to be taken advantage of by unscrupulous providers, nor do they want to be considered mere targets for disease control programmes (they may never have liked that, but they are now certainly becoming more vocal about it). In poor and rich countries, people want more from health care than interventions. Increasingly, there is recognition that the resolution of health problems should take into account the socio-cultural context of the families and communities where they occur\(^ {133}\).

Much public and private health care today is organized around what providers consider to be effective and convenient, often with little attention to or understanding of what is important for their clients\(^ {134}\). Things do not have to be that way. As experience – particularly from industrialized countries – has shown, health services can be made more people-centred. This makes them more effective and also provides a more rewarding working environment\(^ {135}\). Regrettably, developing countries have often put less emphasis on making services more people-centred, as if this were less relevant in resource-constrained circumstances. However, neglecting people’s needs and expectations is a recipe for disconnecting health services from the communities they serve. People-centredness is not a luxury, it is a necessity, also for services catering to the poor. Only people-centred services will minimize social exclusion and avoid leaving people at the mercy of unregulated commercialized health care, where the illusion of a more responsive environment carries a hefty price in terms of financial expense and iatrogenesis.

Securing the health of communities

People do not think about health only in terms of sickness or injury, but also in terms of what they perceive as endangering their health and that of their community\(^ {118}\). Whereas cultural and political explanations for health hazards vary widely, there is a general and growing tendency to hold the authorities responsible for offering protection against, or rapidly responding to such dangers\(^ {136}\). This is an essential part of the social contract that gives legitimacy to the state. Politicians in rich as well as poor countries increasingly ignore their duty to protect people from health hazards at their peril: witness the political fall-out of the poor management of the hurricane Katrina disaster in the United States in 2005, or of the 2008 garbage disposal crisis in Naples, Italy.

Access to information about health hazards in our globalizing world is increasing. Knowledge is spreading beyond the community of health professionals and scientific experts. Concerns about health hazards are no longer limited to the traditional public health agenda of improving
the quality of drinking water and sanitation to prevent and control infectious diseases. In the wake of the 1986 Ottawa Charter for Health Promotion\(^1\), a much wider array of issues constitute the health promotion agenda, including food safety and environmental hazards as well as collective lifestyles, and the social environment that affects health and quality of life\(^2\). In recent years, it has been complemented by growing concerns for a health hazard that used to enjoy little visibility, but is increasingly the object of media coverage: the risks to the safety of patients\(^3\).

Reliable, responsive health authorities
During the 20th century, health has progressively been incorporated as a public good guaranteed by government entitlement. There may be disagreement as to how broadly to define the welfare state and the collective goods that go with it\(^4\), but, in modernizing states, the social and political responsibility entrusted to health authorities – not just ministries of health, but also local governmental structures, professional organizations and civil society organizations with a quasi-governmental role – is expanding.

Circumstances or short-term political expediency may at times tempt governments to withdraw from their social responsibilities for financing and regulating the health sector, or from service delivery and essential public health functions. Predictably, this creates more problems than it solves. Whether by choice or because of external pressure, the withdrawal of the state that occurred in the 1980s and 1990s in China and the former Soviet Union, as well as in a considerable number of low-income countries, has had visible and worrisome consequences for health and for the functioning of health services. Significantly, it has created social tensions that affected the legitimacy of political leadership\(^5\).

In many parts of the world, there is considerable skepticism about the way and the extent to which health authorities assume their responsibilities for health. Surveys show a trend of diminishing trust in public institutions as guarantors of the equity, honesty and integrity of the health sector\(^6\). Nevertheless, on the whole, people expect their health authorities to work for the common good, to do this well and with foresight\(^7\). There is a multiplication of scoring.
cards, rankings and other league tables of public action used either at the national or global level\textsuperscript{44}, while consumer organizations are addressing health sector problems\textsuperscript{111}, and national and global civil society watchdog organizations are emerging\textsuperscript{146,147,148,149}. These recent trends attest to prevailing doubts about how well health authorities are able to provide stewardship for the health system, as well as to the rising expectations for them to do even better.

**Participation**

At the same time, however, surveys show that, as societies modernize, people increasingly want to “have a say” in “important decisions that affect their lives”\textsuperscript{123,112}, which would include issues such as resource allocation and the organization and regulation of care. Experience from countries as diverse as Chile, Sweden and Thailand shows, however, that people are more concerned with having guarantees for fair and transparent processes than with the actual technicalities of priority setting\textsuperscript{150,151}. In other words, an optimum response to aspirations for a bigger say in health policy matters would be evidence of a structured and functional system of checks and balances. This would include relevant stakeholders and would guarantee that the policy agenda could not be hijacked by particular interest groups\textsuperscript{152}.

**PHC reforms: driven by demand**

The core values articulated by the PHC movement three decades ago are, thus, more powerfully present in many settings now than at the time of Alma-Ata. They are not just there in the form of moral convictions espoused by an intellectual vanguard. Increasingly, they exist as concrete social expectations felt and asserted by broad groups of ordinary citizens within modernizing societies. Thirty years ago, the values of equity, people-centredness, community participation and self-determination embraced by the PHC movement were considered radical by many. Today, these values have become widely shared social expectations for health that increasingly pervade many of the world’s societies – though the language people use to express these expectations may differ from that of Alma-Ata.

This evolution from formal ethical principles to generalized social expectations fundamentally alters the political dynamics around health systems change. It opens fresh opportunities for generating social and political momentum to move health systems in the directions people want them to go, and that are summarized in Figure 1.13. It moves the debate from a purely technical discussion on the relative efficiency of various ways of “treating” health problems to include political considerations on the social goals that define the direction in which to steer health systems. The subsequent chapters outline a set of reforms aimed at aligning specialist-based, fragmented and commercialized health systems with these rising social expectations. These PHC reforms aim to channel society’s resources towards more equity and an end to exclusion; towards health services that revolve around people’s needs and expectations; and towards public policies that secure the health of communities. Across these reforms is the imperative of engaging citizens and other stakeholders: recognizing that vested interests that tend to pull health systems in different directions raises the premium on leadership and vision and on sustained learning to do better.

**Figure 1.13** The social values that drive PHC and the corresponding sets of reforms

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Health equity
Solidarity
Social inclusion

Universal coverage reforms
**Chapter 2**

Health authorities that can be relied on

Leadership reforms
**Chapter 5**

People-centred care

Service delivery reforms
**Chapter 3**

Communities where health is promoted and protected

Public policy reforms
**Chapter 4**
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Advancing and sustaining universal coverage

People expect their health systems to be equitable. The roots of health inequities lie in social conditions outside the health system’s direct control. These root causes have to be tackled through intersectoral and cross-government action. At the same time, the health sector can take significant actions to advance health equity internally. The basis for this is the set of reforms that aim at moving towards universal coverage, i.e. towards universal access to health services with social health protection.
The central place of health equity in PHC

“If you get sick, you have to choose: you either go without treatment or you lose the farm.”

Nearly a century ago, the unforgiving reality of life in rural Canada prompted Matthew Anderson (1882–1974) to launch a tax-based health insurance scheme that eventually led to countrywide adoption of universal health care across Canada in 1965. Unfortunately, equally shocking lose-lose situations abound today across the world. More than 30 years after the clarion call of Alma-Ata for greater equity in health, most of the world’s health-care systems continue to rely on the most inequitable method for financing health-care services: out-of-pocket payments by the sick or their families at the point of service. For 5.6 billion people in low- and middle-income countries, over half of all health-care expenditure is through out-of-pocket payments. This deprives many families of needed care because they cannot afford it. Also, more than 100 million people around the world are pushed into poverty each year because of catastrophic health-care expenditures.

While equity marks one of PHC’s boldest features, it is one of the areas where results have been most uneven and where the premium for more effective reforms is perhaps the greatest. Out-of-pocket payments for health care are but one of the sources of health inequity. Deeply unequal opportunities for health combined with endemic inequalities in health care provision lead to pervasive inequities in health outcomes.

Growing awareness of these regressive patterns is causing increasing intolerance of the whole spectrum of unnecessary, avoidable and unfair differences in health.

The extent of health inequities is documented in much more detail today. They stem from social stratification and political inequalities that lie outside the boundaries of the health system. Income and social status matter, as do the neighbourhoods where people live, their employment conditions and factors, such as personal behaviour, race and stress.

Health inequities also find their roots in the way health systems exclude people, such as inequities in availability, access, quality and burden of payment, and even in the way clinical practice is conducted. Left to their own devices, health systems do not move towards greater equity. Most health services – hospitals in particular, but also first-level care – are consistently inequitable providing more and higher quality services to the well-off than to the poor, who are in greater need. Differences in vulnerability and exposure combine with inequalities in health care to lead to unequal health outcomes; the latter further contribute to the social stratification that led to the inequalities in the first place. People are rarely indifferent to this cycle of inequalities, making their concerns as relevant to politicians as they are to health-system managers.

It takes a wide range of interventions to tackle the social determinants of health and make health systems contribute to more health equity. These interventions reach well beyond the traditional realm of health-service policies, relying on the mobilization of stakeholders and constituencies outside the health sector. They include:

- reduction of social stratification, e.g. by reducing income inequality through taxes and subsidized public services, providing jobs with
adequate pay, using labour intensive growth strategies, promoting equal opportunities for women and making free education available, etc.;
- reduction of vulnerabilities, e.g. by providing social security for the unemployed or disabled, developing social networks at community level, introducing social inclusion policies and policies that protect mothers while working or studying, offering cash benefits or transfers, providing free healthy lunches at school, etc.;
- protection, particularly of the disadvantaged, against exposure to health hazards, e.g. by introducing safety regulations for the physical and social environment, providing safe water and sanitation, promoting healthy lifestyles, establishing healthy housing policies, etc.;
- mitigation of the consequences of unequal health outcomes that contribute to further social stratification, e.g. by protecting the sick from unfair dismissal from their jobs.

The need for such multiple strategies could discourage some health leaders who might feel that health inequality is a societal problem over which they have little influence. Yet, they do have a responsibility to address health inequality. The policy choices they make for the health sector define the extent to which health systems exacerbate or mitigate health inequalities and their capacity to mobilize around the equity agenda within government and civil society. These choices also play a key part in society’s response to citizens’ aspirations for more equity and solidarity. The question, therefore, is not if, but how health leaders can more effectively pursue strategies that will build greater equity in the provision of health services.

Moving towards universal coverage

The fundamental step a country can take to promote health equity is to move towards universal coverage: universal access to the full range of personal and non-personal health services they need, with social health protection. Whether the arrangements for universal coverage are tax-based or are organized through social health insurance, or a mix of both, the principles are the same: pooling pre-paid contributions collected on the basis of ability to pay, and using these funds to ensure that services are available, accessible and produce quality care for those who need them, without exposing them to the risk of catastrophic expenditures. Universal coverage is not, by itself, sufficient to ensure health for all and health equity – inequalities persist in countries with universal or near-universal coverage – but it provides the necessary foundation.

While universal coverage is fundamental to building health equity, it has rarely been the object of an easy social consensus. Indeed, in countries where universal coverage has been achieved or embraced as a political goal, the idea has often met with strong initial resistance, for example, from associations of medical professionals concerned about the impact of government-managed health insurance schemes on their incomes and working conditions, or from financial experts determined to rein in public spending. As with other entitlements that are now taken for granted in almost all high-income countries, universal health coverage has generally been struggled for and won by social movements, not spontaneously bestowed by political leaders. There is now widespread consensus that providing such coverage is simply part of the package of core obligations that any legitimate government must fulfil vis-à-vis its citizens. In itself, this is a political achievement that shapes the modernization of society.

Industrialized countries, particularly in Europe, began to put social health protection schemes in place in the late 19th century, moving towards universalism in the second half of the 20th century. The opportunity now exists for low- and middle-income countries to implement comparable approaches. Costa Rica, Mexico, the Republic of Korea, Thailand and Turkey are among the countries that have already introduced ambitious universal coverage schemes, moving significantly faster than industrialized countries did in the past. Other countries are weighing similar options. The technical challenge of moving towards universal coverage is to expand coverage in three ways (Figure 2.2).

The breadth of coverage – the proportion of the population that enjoys social health protection – must expand progressively to encompass
the uninsured, i.e. the population groups that lack access to services and/or social protection against the financial consequences of taking up health care. Expanding the breadth of coverage is a complex process of progressive expansion and merging of coverage models (Box 2.1). During this process, care must be taken to ensure safety nets for the poorest and most vulnerable until they also are covered. It may take years to cover the entire population but, as recent experience from a number of middle-income countries shows, it is possible to move much faster than was the case for industrialized countries during the 20th century.

Meanwhile, the depth of coverage must also grow, expanding the range of essential services that are necessary to address people’s health needs effectively, taking into account demand and expectations, and the resources society is willing and able to allocate to health. The determination of the corresponding “essential package” of benefits can play a key role here, provided the process is conducted appropriately (Box 2.2).

The third dimension, the height of coverage, i.e. the portion of health-care costs covered through pooling and pre-payment mechanisms must also rise, diminishing reliance on out-of-pocket co-payments at the point of service delivery. In the 1980s and 1990s, many countries introduced user fees in an effort to infuse new resources into struggling services, often in a context of disengagement of the state and dwindling public resources for health. Most undertook these measures without anticipating the extent of the damage they would do. In many settings, dramatic declines in service use ensued, particularly among vulnerable groups, while the frequency of catastrophic expenditure increased. Some countries have since reconsidered their position and have started phasing out user fees and replacing the lost income from pooled funds (government subsidies or contracts, insurance

Box 2.1 Best practices in moving towards universal coverage

**Emphasize pre-payment from the start.** It may take many years before access to health services and financial protection against the costs involved in their use are available for all: it took Japan and the United Kingdom 36 years. The road may seem discouragingly long, particularly for the poorest countries, where health-care networks are sparsely developed, financial protection schemes embryonic and the health sector highly dependent on external funds. Particularly in these countries, however, it is crucial to move towards pre-payment systems from a very early stage and to resist the temptation to rely on user fees. Setting up and maintaining appropriate mechanisms for pre-payment builds the institutional capacity to manage the financing of the system along with the extension of service supply that is usually lacking in such contexts.

**Coordinate funding sources.** In order to organize universal coverage, it is necessary to consider all sources of funding in a country: public, private, external and domestic. In low-income countries, it is particularly important that international funding be channelled through nascent pre-payment and pooling schemes and institutions rather than through project or programme funding. Routing funds in this way has two purposes. It makes external funding more stable and predictable and helps build the institutional capacity to develop and extend supply, access and financial protection in a balanced way.

**Combine schemes to build towards full coverage.** Many countries with limited resources and administrative capacity have experimented with a multitude of voluntary insurance schemes: community, cooperative, employer-based and other private schemes, as a way to foster pre-payment and pooling in preparation for the move towards more comprehensive national systems. Such schemes are no substitute for universal coverage although they can become building blocks of the universal system. Realizing universal coverage means coordinating or combining these schemes progressively into a coherent whole that ensures coverage to all population groups and builds bridges with broader social protection programmes.
Chapter 2. Advancing and sustaining universal coverage

This has resulted in substantial increases in the use of services, especially by the poor. In Uganda, for example, service use increased suddenly and dramatically and the increase was sustained after the elimination of user fees (Figure 2.3).

Pre-payment and pooling institutionalizes solidarity between the rich and the less well-off, and between the healthy and the sick. It lifts barriers to the uptake of services and reduces the risk that people will incur catastrophic expenses when they are sick. Finally, it provides the means to re-invest in the availability, range and quality of services.

### Challenges in moving towards universal coverage

All universal coverage reforms have to find compromises between the speed with which they increase coverage and the breadth, depth and height of coverage. However, the way countries devise their strategies and focus their reforms very much depends on their specific national contexts.

In some countries, a very large part of the population lives in extremely deprived areas, with an absent or dysfunctional health-care infrastructure. These are countries of mass exclusion typically brought to mind when one talks about “scaling up”: the poor and remote rural areas where health-care networks have not been deployed yet or where, after years of neglect, the health infrastructure continues to exist in name only. Such patterns occur in low-income countries.
such as Bangladesh, Chad and Niger (Figure 2.4), and are common in conflict and post-conflict areas where health workers have departed and the health infrastructure has been destroyed and needs to be rebuilt from scratch.

In other parts of the world, the challenge is in providing health support to widely dispersed populations, for example, in small island states, remote desert or mountainous regions, and among nomadic and some indigenous populations. Ensuring access to quality care in these settings entails grappling with the diseconomies of scale connected with small, scattered populations; logistical constraints on referral; difficulties linked to limited infrastructure and communications capacities; and, in some cases, more specific technical complications, such as maintaining patient records for nomadic groups.

A different challenge is extending coverage in settings where inequalities do not result from the lack of available health infrastructure, but from the way health care is organized, regulated and, above all, paid for by official or under-the-counter user charges. These are situations where under-utilization of available services is concentrated among the poor, whereas users are exposed to the risks of catastrophic expenditure. Such patterns of exclusion occur in countries such as Colombia, Nicaragua and Turkey (Figure 2.4). It is particularly striking in the many urban areas of low- and middle-income countries where a plethora of assorted, unregulated, commercial health-care providers charge users prohibitive fees while providing inadequate services.

Ways of tackling the situations described in this section are elaborated below.

**Rolling out primary-care networks to fill the availability gap**

In areas where no health services are available for large population groups, or where such services are grossly inadequate or fragmented, the basic health-care infrastructure needs to be built or rebuilt, often from the ground up. These areas are always severely resource-constrained and frequently affected by conflicts or complex emergencies, while the scale of under-servicing, also in other sectors, engenders logistical difficulties and problems in deploying health professionals. Health planners in these settings face a fundamental strategic dilemma: whether to prioritize a massive scale-up of a limited set of interventions to the entire population or a progressive roll-out of more comprehensive primary-care systems on a district-by-district basis.

Some would advocate, in the name of speed and equity, an approach in which a restricted number of priority programmes is rolled out simultaneously to all the inhabitants in the deprived areas. This allows for task shifting to low-skilled personnel, lay workers and volunteers and, consequently, rapid extension of coverage. It is still central to what the global community often prescribes for the rural areas of the poorest countries, and quite a number of countries have chosen this option over the last 30 years. Ethiopia, for example, is currently deploying 30 000 health extension workers to provide massive numbers of people with a limited package of priority preventive interventions. The poor skills base is often well recognized as a limiting factor, but Ethiopia’s extension workers are no longer as low skilled as they once were, and currently benefit from a year of post-Grade 10 training. Nevertheless, skill limitations reinforce the focus on a limited number of effective but simple interventions.

Scaling up a limited number of interventions has the advantage of rapidly covering the entire population and focusing resources on what is known to be cost effective. The downside is that
when people experience health problems, they want them to be dealt with, whether or not they fit nicely within the programmatic priorities that are being proposed. Ignoring this dimension of demand too much opens the door to “drug peddlers”, “injectors” and other types of providers, who can capitalize on commercial opportunities arising from unmet health needs. They offer patients an appealing alternative, but one that is often exploitative and harmful. Compared with a situation of utter lack of health action, there is an indisputable benefit in scaling up even a very limited package of interventions and the possibility of relying on low-skilled staff makes it an attractive option. However, upgrading often proves more difficult than initially envisaged and, in the meantime, valuable time, resources and credibility are lost which might have allowed for investment in a more ambitious, but also more sustainable and effective primary-care infrastructure.

The alternative is a progressive roll-out of primary care, district-by-district, of a network of health centres with the necessary hospital support. Such a response obviously includes the priority interventions, but integrated in a comprehensive primary-care package. The extension platform is the primary-care centre: a professionalized infrastructure where the interface with the community is organized, with a problem solving capacity and modular expansion of the range of activities. The Islamic Republic of Iran’s progressive roll-out of rural coverage is an impressive example of this model. As one of the fathers of the country’s PHC strategy put it: “Since it was impossible to launch the project in all provinces at the same time, we decided to focus on a single province each year” (Box 2.3).

The limiting factors for a progressive roll-out of primary-care networks are the lack of a stable cadre of mid-level staff with the leadership qualities to organize health districts and with the ability to maintain, over the years, the constant effort required to build sustainable results for the entire population. Where the roll-out has been conducted as an administrative exercise, it has led to disappointment: many health districts exist in name only. But where impatience and pressure for short-term visibility has been managed adequately, a blend of response to need and demand, and participation of the population and key actors has made it possible to build robust primary-care networks, even in very difficult and resource-constrained settings of conflict, and post-conflict environments (Box 2.4).
The distinction between rapid deployment of priority interventions and progressive roll-out of primary-care networks is, in practice, often not as straightforward as described above. However, for all the convergence, trying to balance speed and sustainability is a real political dilemma. Mali, among others, has shown that, given the choice, people willingly opt for progressive roll-out, making community health centres – whose infrastructure is owned and personnel employed by the local community – the basis of functional health districts.

Crucially, concern for equity should not be translated into a “lowest common denominator” approach: equal access for all to a set of largely unsatisfactory services. Quality and sustainability are important, particularly since nowadays the multitude of varied and dynamic governmental, not-for-profit and for-profit private providers of various kinds are in dire need of alignment. Progressive roll-out of health services provides the opportunity to establish welcome leadership coherence in health-care provision at district level. Typical large-scale examples of this approach in developing countries are the contracting out of district health services in Cambodia, or the incorporation of missionary “designated district hospitals” in East Africa. Nevertheless, there is no getting away from the need for massive and sustained investment to expand and maintain health districts in the long term and from the fact that this represents a considerable challenge in a context of sluggish economic growth and stagnating health expenditure.

Extending health-care networks to underserved areas depends on public initiative and incentives. One way to accelerate the extension of coverage is to adjust budget allocation formulae (or contract specifications) to reflect the extra efforts required to contact hard-to-reach populations. Several countries have taken steps in this direction. In January 2004, for example, the United Republic of Tanzania adopted a revised formula for the allocation of basket funds to districts that includes population size and under-five mortality as a proxy for disease burden and poverty level, while adjusting for the differential costs of providing health services in rural and low-density areas. Similarly, allocations to districts under Uganda’s PHC budget factor in the districts’ Human Development Index and levels of external health funding, in addition to population size. Supplements are paid to districts with difficult security situations or lacking a district hospital. In Chile, budgets are allocated on a capitation basis but, as part of the PHC reforms, these were adjusted using municipal human development indices and a factor to reflect the isolation of underserved areas.

**Overcoming the isolation of dispersed populations**

Although providing access to services for dispersed populations is often a daunting logistical challenge, some countries have dealt with it by developing creative approaches. Devising mechanisms to share innovative experiences and results has clearly been a key step, for example, through the “Healthy Islands” initiative, launched at the meeting of Ministers and Heads of Health in Yanuca, Fiji, in 1995. The initiative brings together health policy-makers and practitioners to address challenges to islanders’ health and well-being from an explicitly multi-sectoral perspective, with a focus on expanding coverage of curative health-care services, but also reinforcing promotive strategies and cross-sectoral action on the determinants of health and health equity.

Through the Healthy Islands initiative and related experiences, a number of principles have emerged as crucial to the advancement of universal coverage in these settings. The first concerns collaboration in organizing infrastructure that maximizes scales of efficiency. An isolated community may be unable to afford key inputs to expand coverage, which includes infrastructure, technologies and human resources (particularly the training of personnel). However, when communities join forces, they can secure such inputs at manageable costs. A second strategic focus is on “mobile resources” or those that can overcome distance and geographical obstacles efficiently and affordably. Depending on the setting, this strategic focus may include transportation, radio communications, and other information and communications technologies. Telecommunications
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Box 2.4 The robustness of PHC-led health systems: 20 years of expanding performance in Rutshuru, the Democratic Republic of the Congo

Rutshuru is a health district in the east of the country. It has a network of health centres, a referral hospital and a district management team where community participation has been fostered for years through local committees. Rutshuru has experienced severe stress over the years, testing the robustness of the district health system.

Over the last 30 years, the economy of the country has gone into a sharp decline. GDP dropped from US$ 300 per capita in the 1980s to below US$ 100 at the end of the 1990s. Massive impoverishment was made worse as the State retreated from the health sector. This was compounded by an interruption of overseas development aid in the early 1990s. In that context, Rutshuru suffered inter-ethnic strife, a massive influx of refugees and two successive wars. This complex of disasters severely affected the working conditions of health professionals and access to health services for the 200 000 people living in the district.

Nevertheless, instead of collapsing, PHC services continued their expansion over the years. The number of health centres and their output increased (Figure 2.6), and quality of care improved for acute cases (case-fatality rate after caesarean section dropped from 7% to less than 3%) as well as for chronic patients (at least 60% of tuberculosis patients were treated successfully). With no more than 70 nurses and three medical doctors at a time, and in the midst of war and havoc, the health centres and the district hospital took care of more than 1 500 000 disease episodes in 20 years, immunized more than 100 000 infants, provided midwifery care to 70 000 women and carried out 8 000 surgical procedures. This shows that, even in disastrous circumstances, a robust district health system can improve health-care outputs.

These results were achieved with modest means. Out-of-pocket payments amounted to US$ 0.5 per capita per year. Nongovernmental organizations subsidized the district with an average of US$ 1.5 per capita per year. The Government’s contribution was virtually nil during most of these 20 years. The continuity of the work under extremely difficult circumstances can be explained by team work and collegial decision-making, unrelenting efforts to build up and maintain a critical mass of dedicated human resources, and limited but constant nongovernmental support, which provided a minimum of resources for health facilities and gave the district management team the opportunity to maintain contact with the outside world.

Three lessons can be learnt from this experience. In the long run, PHC-led health districts are an organizational model that has the robustness to resist extremely adverse conditions. Maintaining minimal financial support and supervision to such districts can yield very significant results, while empowering and retaining national health professionals. Local health services have a considerable potential for coping with crises.

Figure 2.6 Improving health-care outputs in the midst of disaster: Rutshuru, the Democratic Republic of the Congo, 1985–2004

... can enable less skilled frontline health-centre staff to be advised and guided by experts at a distance in real time. Finally, the financing of health care for dispersed populations poses specific challenges, which often require larger per capita expenditure compared to more clustered populations. In countries whose territories include both high-density and low-density populations, it is expected that dispersed populations will receive some subsidy of care. After all, equity does not come without solidarity.

Providing alternatives to unregulated commercial services

In urban and periurban contexts, health services are physically within reach of the poor and other vulnerable populations. The presence of multiple health-care providers does not mean, however, that these groups are protected from diseases, nor that they can get quality care when they need it: the more privileged tend to get better access to the best services, public and private, easily coming out on top in a de facto competition for scarce...
resources. In the urban and increasingly in the rural areas of many low- and middle-income countries – from India and Viet Nam to sub-Saharan Africa – much health care for the poor is provided by small-scale, largely unregulated and often unlicensed providers, both commercial and not-for-profit. Often, they work alongside dysfunctional public services and capture an overwhelmingly large part of the health-care market, while the health promotion and prevention agenda is totally ignored. Vested interests make the promotion of universal coverage paradoxically more difficult in these circumstances than in areas where the challenge is to build health-care delivery networks from scratch.

These contexts often combine problems of financial exploitation, bad quality and unsafe care, and exclusion from needed services. The Pan American Health Organization (PAHO) has estimated that 47% of Latin America’s population is excluded from needed services. This may be for broader reasons of poverty, ethnicity or gender, or because the resources of the health system are not correctly targeted. It may be because there are no adequate systems to protect people against catastrophic expenditure or from financial exploitation by unscrupulous or insensitive providers. It may have to do with the way people, rightly or wrongly, perceive health services: lack of trust, the expectation of ill-treatment or discrimination, uncertainty about the cost-of-care, or the anticipation that the cost will be unaffordable or catastrophic. Services may also be untimely, ineffective, unresponsive or plain discriminatory, providing poorer patients with inferior treatment. As a result, health outcomes vary considerably by social class, even in well-regulated and well-funded health-care systems.

In addressing these patterns of exclusion within the health-care sector, the starting point is to create or strengthen networks of accessible quality primary-care services that rely on pooled pre-payment or public resources for their funding. Whether these networks are expanded by contracting commercial or not-for-profit providers, or by revitalizing dysfunctional public facilities is not the critical issue. The point is to ensure that they offer care of an acceptable standard. A critical mass of primary-care centres that provide an essential package of quality services free-of-charge, provides an important alternative to substandard, exploitative commercial care. Furthermore, peer pressure and consumer demand can help to create an environment in which regulation of the commercial sector becomes possible. More active involvement of municipal authorities in pre-payment and pooling schemes to improve the supply of quality care is probably one of the avenues to follow, particularly where ministries of health with budgetary constraints also have to extend services to underserved rural areas.

Targeted interventions to complement universal coverage mechanisms

Rising average national income, a growing supply of health-care providers and accelerated progress towards universal coverage are, unfortunately, not sufficient to eliminate health inequities. Socially determined health differences among population groups persist in high-income countries with robust, universal health-care and social-service systems, such as Finland and France. Health inequalities do not just exist between the poor and the non-poor, but across the entire socioeconomic gradient. There are circumstances where other forms of exclusion are of prime concern, including the exclusion of adolescents, ethnic groups, drug users and those affected by stigmatizing diseases. In Australia, Canada and New Zealand, among others, health equity gaps between Aboriginal and non-Aboriginal populations have emerged as national political issues. In other settings, inequalities in women’s access to health care merit attention. In the United States, for example, declines in female life expectancy of up to five years in over 1000 counties point to differential exposure and clustering of risks to health even as the country’s economy and health sector continues to grow. For a variety of reasons, some groups within these societies are either not reached or insufficiently reached by opportunities for health or services and continue to experience health outcomes systematically inferior to those of more advantaged groups.
Thus, it is necessary to embed universal coverage in wider social protection schemes and to complement it with specially designed, targeted forms of outreach to vulnerable and excluded groups\textsuperscript{57}. Established health-care networks often do not make all possible efforts to ensure that everyone in their target population has access to the full range of health benefits they need, as this requires extra efforts, such as home visits, outreach services, specialized language and cultural facilitation, evening consultations, etc. These may, however, mitigate the effect of social stratification and inequalities in the uptake of services\textsuperscript{58}. They may also offer the opportunity to construct comprehensive support packages to foster social inclusion of historically marginalized populations, in collaboration with other government sectors and with affected communities. Chile’s \textit{Chile Solidario} (Chilean Solidarity) model of outreach to families in long-term poverty is one example (Box 2.5)\textsuperscript{59}. Such targeted measures may include subsidizing people – not services – to take up specific health services, for example, through vouchers\textsuperscript{60,61} for maternal care as in India and Yemen, for bednets as in the United Republic of Tanzania\textsuperscript{62,63}, for contraceptive uptake by adolescents\textsuperscript{64} or care for the elderly uninsured as in the United States\textsuperscript{65}. Conditional cash transfers, where the beneficiary is not only enabled, but compelled to take up services is another model, which has been introduced in several countries in Latin America. A recent systematic review of six such programmes suggests that conditional cash transfers can be effective in increasing the use of preventive services and improving nutritional and anthropometric outcomes, sometimes improving health status\textsuperscript{66}. However, their overall effect on health status remains less clear and so does their comparative advantage over traditional, unconditional, income maintenance, through universal entitlements, social insurance or – less-effective – means-tested social assistance.

Targeted measures are not substitutes for the long-term drive towards universal coverage. They can be useful and necessary complements, but without simultaneous institutionalization of the financing models and system structures that support universal coverage, targeted approaches are unlikely to overcome the inequalities generated by socioeconomic stratification and exclusion. This is all the more important since systematic evaluation of methods to target the excluded is scarce and marred by the limited number of documented experiences and a bias towards reporting preferentially on successful pilots\textsuperscript{67}. If anything definite can be said today, it is that the strategies for reaching the unreached will have to be multiple and contextualized, and that no single targeting measure will suffice to correct health inequalities effectively, certainly not in the absence of a universal coverage policy.

\begin{center}
\textbf{Box 2.5 Targeting social protection in Chile}\textsuperscript{68}
\end{center}

Established by law, the Chilean social protection programme (\textit{Chile Solidario}) involves three main components to improve conditions for people living in extreme poverty: direct psycho-social support, financial support and priority access to social programmes. The direct psycho-social support component involves families in extreme poverty being identified according to pre-defined criteria and invited to enter into an agreement with a designated social worker. The social worker assists them to build individual and family capacities that help them to strengthen their links with social networks and to gain access to the social benefits to which they are entitled. In addition to psycho-social support, there is also financial support in terms of cash transfers and pensions, as well as subsidies for raising families or covering water and sanitation costs. Finally, the social protection programme also provides preferential access to pre-school programmes, adult literacy courses, employment programmes and preventive health visits for women and children.

This social protection programme complements a multisectoral effort targeting all children aged 0–18 years (\textit{Chile Crece Contigo} – Chile Grows with You). The aim is to promote early childhood development through pre-school education programmes, preventive health checks, improved parental leave and increased child benefits. Better access to child-care services is also included as is enforcing the right of working mothers to nurse their babies, which is designed to stimulate women’s insertion into the employment market.
Mobilizing for health equity

Health systems are invariably inequitable. More and higher quality services gravitate to the well-off who need them less than the poor and marginalized. The universal coverage reforms required to move towards greater equity demand the enduring commitment of the highest political levels of society. Two levers may be especially important in accelerating action on health equity and maintaining momentum over time. The first is raising the visibility of health inequities in public awareness and policy debates: the history of progress in the health of populations is intimately linked to the measurement of health inequalities. It was the observation of excess mortality among the working class that informed the “Great Sanitary Awakening” reforms of the Poor Laws Commission in the United Kingdom in the 1830s. The second is the creation of space for civil society participation in shaping the PHC reforms that are to advance health equity: the history of progress in universal coverage is intimately linked to that of social movements.

Increasing the visibility of health inequities

With the economic optimism of the 1960s and 1970s (and the expansion of social insurance in industrialized countries), poverty ceased being a priority issue for many policy-makers. It took Alma-Ata to put equity back on the political agenda. The lack of systematic measurement and monitoring to translate this agenda into concrete challenges has long been a major constraint in advancing the PHC agenda. In recent years, income-related and other health inequalities have been studied in greater depth. The introduction of composite asset indices has made it possible to reanalyze demographic and health surveys from an equity viewpoint. This has generated a wealth of documentary evidence on socioeconomic differentials in health outcomes and access to care. It took this acceleration of the measurement of poverty and inequalities, particularly since the mid-1990s, to bring first poverty and then, more generally, the challenge of persisting inequalities to the centre of the health policy debate.

Measurement of health inequities is paramount when confronting the common misperceptions that strongly influence health policy debates.

- Simple population averages are sufficient to assess progress – they are not.
- Health systems designed for universal access are equitable – they are a necessary, but not a sufficient condition.
- In poor countries, everybody is equally poor and equally unhealthy – all societies are stratified.
- The main concern is between countries’ differences – inequalities within countries matter most to people.
- Well-intended reforms to improve efficiency will ultimately benefit everybody – they often have unintended inequitable consequences.

Measurement matters for a variety of reasons.

- It is important to know the extent and understand the nature of health inequalities and exclusion in a given society, so as to be able to share that information and translate it into objectives for change.
- It is equally important, for the same reasons, to identify and understand the determinants of health inequality not only in general terms, but also within each specific national context. Health authorities must be informed of the extent to which current or planned health policies contribute to inequalities, so as to be able to correct them.
- Progress with reforms designed to reduce health inequalities, i.e. progress in moving towards universal coverage, needs to be monitored, so as to steer and correct these reforms as they unfold.

Despite policy-makers’ long-held commitment to the value of equity in health, its definition and measurement represent a more recent public health science. Unless health information systems collect data using standardized social stratifiers, such as socioeconomic status, gender, ethnicity and geographical area, it is difficult to identify and locate inequalities and, unless their magnitude and nature are uncovered, it is unlikely that they will be adequately addressed. The now widely available analyses of Demographic and Health Survey (DHS) data by asset quintiles...
have made a major difference in the awareness of policy-makers about health equity problems in their countries. There are also examples of how domestic capacities and capabilities can be strengthened to better understand and manage equity problems. For example, Chile has recently embarked on integrating health sector information systems in order to have more comprehensive information on determinants and to improve the ability to disaggregate information according to socioeconomic groups. Indonesia has added health modules to household expenditure and demographic surveys. Building in capabilities, across administrative database systems, to link health and socioeconomic data through unique identifiers (national insurance numbers or census geo-codes) is key to socioeconomic stratification and provides information that is usually inaccessible. However, this is more than a technical challenge. Measuring health systems’ progress towards equity requires an explicit deliberative process to identify what constitutes a fair distribution of health against shortfalls and gaps that can be measured. It relies on the development of institutional collaboration between multiple stakeholders to ensure that measurement and monitoring translates into concrete political proposals for better equity and solidarity.

Creating space for civil society participation and empowerment

Knowledge about health inequalities can only be translated into political proposals if there is organized social demand. Demand from the communities that bear the burden of existing inequalities and other concerned groups in civil society are among the most powerful motors driving universal coverage reforms and efforts to reach the unreached and the excluded.

The amount of grassroots advocacy to improve the health and welfare of populations in need has grown enormously in the last 30 years, mostly within countries, but also globally. There are now thousands of groups around the world, large and small, local and global, calling for action to improve the health of particularly deprived social groups or those suffering from specific health conditions. These groups, which were virtually non-existent in the days of the Alma-Ata, constitute a powerful voice of collective action.
The mobilization of groups and communities to address what they consider to be their most important health problems and health-related inequalities is a necessary complement to the more technocratic and top-down approach to assessing social inequalities and determining priorities for action.

Many of these groups have become capable lobbyists, for example, by gaining access to HIV/AIDS treatment, abolishing user fees and promoting universal coverage. However, these achievements should not mask the contributions that the direct engagement of affected communities and civil society organizations can have in eliminating sources of exclusion within local health services. Costa Rica’s “bias-free framework” is one example among many. It has been used successfully to foster dialogue with and among members of vulnerable communities by uncovering local practices of exclusion and barriers to access not readily perceived by providers and by spurring action to address the underlying causes of ill-health. Concrete results, such as the reorganization of a maternity hospital around the people’s needs and expectations can transcend the local dimension, as was the case in Costa Rica when local reorganization was used as a template for a national effort.

However, there is much the health system itself can do to mitigate the effects of social inequities and promote fairer access to health services at local level. Social participation in health action becomes a reality at the local level and, at times, it is there that intersectoral action most effectively engages the material and social factors that shape people’s health prospects, widening or reducing health equity gaps. One such example is the Health Action Zones in the United Kingdom, which were partner-based entities whose mission was to improve the well-being of disadvantaged groups. Another example is the work of the municipality of Barcelona, in Spain, where a set of interventions, including the reform of primary care, was followed by health improvements in a number of disadvantaged groups, showing that local governments can help reduce health inequities.

Local action can also be the starting point for broader structural changes, if it feeds into relevant political decisions and legislation (Box 2.6). Local health services have a critical role to play in this regard, as it is at this level that universal coverage and service delivery reforms meet. Primary care is the way of organizing health-care delivery that is best geared not only to improving health equity, but also to meeting people’s other basic needs and expectations.
References

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This chapter describes how primary care brings promotion and prevention, cure and care together in a safe, effective and socially productive way at the interface between the population and the health system. In short, what needs to be done to achieve this is “to put people first”: to give balanced consideration to health and well-being as well as to the values and capacities of the population and the health workers. The chapter starts by describing features of health care that, along with effectiveness and safety, are essential in ensuring improved health and social outcomes.
These features are person-centredness, comprehensiveness and integration, and continuity of care, with a regular point of entry into the health system, so that it becomes possible to build an enduring relationship of trust between people and their health-care providers. The chapter then defines what this implies for the organization of health-care delivery: the necessary switch from specialized to generalist ambulatory care, with responsibility for a defined population and the ability to coordinate support from hospitals, specialized services and civil society organizations.

**Good care is about people**

Biomedical science is, and should be, at the heart of modern medicine. Yet, as William Osler, one of its founders, pointed out, “it is much more important to know what sort of patient has a disease than what sort of disease a patient has”\(^2\). Insufficient recognition of the human dimension in health and of the need to tailor the health service’s response to the specificity of each community and individual situation represent major shortcomings in contemporary health care, resulting not only in inequity and poor social outcomes, but also diminishing the health outcome returns on the investment in health services.

Putting people first, the focus of service delivery reforms is not a trivial principle. It can require significant – even if often simple – departures from business as usual. The reorganization of a medical centre in Alaska in the United States, accommodating 45,000 patient contacts per year, illustrates how far-reaching the effects can be. The centre functioned to no great satisfaction of either staff or clients until it decided to establish a direct relationship between each individual and family in the community and a specific staff member\(^3\). The staff were then in a position to know “their” patients’ medical history and understand their personal and family situation. People were in a position to get to know and trust their health-care provider: they no longer had to deal with an institution but with their personal caregiver. Complaints about compartmentalized and fragmented services abated\(^4\). Emergency room visits were reduced by approximately 50% and referrals to specialty care by 30%; waiting times shortened significantly. With fewer “rebound” visits for unresolved health problems, the workload actually decreased and staff job satisfaction improved. Most importantly, people felt that they were being listened to and respected – a key aspect of what people value about health care\(^5,6\). A slow bureaucratic system was thus transformed into one that is customer-responsive, customer-owned and customer-driven\(^4\).

In a very different setting, the health centres of Ouallam, a rural district in Niger, implemented an equally straightforward reorganization of their way of working in order to put people first. Rather than the traditional morning curative care consultation and specialized afternoon clinics (growth monitoring, family planning, etc.), the full range of services was offered at all times, while the nurses were instructed to engage in an active dialogue with their patients. For example, they no longer waited for women to ask for contraceptives, but informed them, at every contact, about the range of services available. Within a few months, the very low uptake of family planning, previously attributed to cultural constraints, was a thing of the past (Figure 3.1)\(^7\).

People’s experiences of care provided by the health system are determined first and foremost by the way they are treated when they experience a problem and look for help: by the responsiveness of the health-worker interface between population...
and health services. People value some freedom in choosing a health provider because they want one they can trust and who will attend to them promptly and in an adequate environment, with respect and confidentiality.

Health-care delivery can be made more effective by making it more considerate and convenient, as in Ouallam district. However, primary care is about more than shortening waiting times, adapting opening hours or getting staff to be more polite. Health workers have to care for people throughout the course of their lives, as individuals and as members of a family and a community whose health must be protected and enhanced, and not merely as body parts with symptoms or disorders that require treating.

The service delivery reforms advocated by the PHC movement aim to put people at the centre of health care, so as to make services more effective, efficient and equitable. Health services that do this start from a close and direct relationship between individuals and communities and their caregivers. This, then, provides the basis for person-centredness, continuity, comprehensiveness and integration, which constitute the distinctive features of primary care. Table 3.1 summarizes the differences between primary care and care provided in conventional settings, such as in clinics or hospital outpatient departments, or through the disease control programmes that shape many health services in resource-limited settings. The section that follows reviews these defining features of primary care, and describes how they contribute to better health and social outcomes.

The distinctive features of primary care

Effectiveness and safety are not just technical matters

Health care should be effective and safe. Professionals as well as the general public often over-rate the performance of their health services. The emergence of evidence-based medicine in the 1980s has helped to bring the power and discipline of scientific evidence to health-care decision-making, while still taking into consideration patient values and preferences.

Over the last decade, several hundred reviews of

<table>
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<tr>
<th>Conventional ambulatory medical care in clinics or outpatient departments</th>
<th>Disease control programmes</th>
<th>People-centred primary care</th>
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</thead>
<tbody>
<tr>
<td>Focus on illness and cure</td>
<td>Focus on priority diseases</td>
<td>Focus on health needs</td>
</tr>
<tr>
<td>Relationship limited to the moment of consultation</td>
<td>Relationship limited to programme implementation</td>
<td>Enduring personal relationship</td>
</tr>
<tr>
<td>Episodic curative care</td>
<td>Programme-defined disease control interventions</td>
<td>Comprehensive, continuous and person-centred care</td>
</tr>
<tr>
<td>Responsibility limited to effective and safe advice to the patient at the moment of consultation</td>
<td>Responsibility for disease-control targets among the target population</td>
<td>Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill-health</td>
</tr>
<tr>
<td>Users are consumers of the care they purchase</td>
<td>Population groups are targets of disease-control interventions</td>
<td>People are partners in managing their own health and that of their community</td>
</tr>
</tbody>
</table>
Evidence-based medicine, however, cannot in itself ensure that health care is effective and safe. Growing awareness of the multiple ways in which care may be compromised is contributing to a gradual rise in standards of quality and safety (Box 3.1). Thus far, however, such efforts have concentrated disproportionately on hospital and specialist care, mainly in high- and middle-income countries. The effectiveness and safety of generalist ambulatory care, where most interactions between people and health services take place, has been given much less attention\(^{14}\). This is a particularly important issue in the unregulated commercial settings of many developing countries where people often get poor value for money (Box 3.2)\(^{15}\).

Technical and safety parameters are not the only determinants of the outcomes of health care. The disappointingly low success rate in preventing mother-to-child transmission (MTCT) of HIV in a study in the Côte d’Ivoire (Figure 3.2) illustrates that other features of the organization of health care are equally critical—good drugs are administered worldwide each year are given with syringes and needles that are reused without sterilization and cause 1.3 million deaths and almost 26 million years of life lost, mainly because of transmission of hepatitis B and C, and HIV\(^{16}\). Especially disquieting is the paucity of information on the extent and determinants of unsafe care in low- and middle-income countries. With unregulated commercialization of care, weaker quality control and health resource limitations, healthcare users in low-income countries may well be even more exposed to the risk of unintended patient harm than patients in high-income countries. The World Alliance for Patient Safety\(^{22}\), among others, advocates making patients safer through systemic interventions and a change in organizational culture rather than through the denunciation of individual health-care practitioners or administrators\(^{23}\).

**Box 3.1 Towards a science and culture of improvement: evidence to promote patient safety and better outcomes**

The outcome of health care results from the balance between the added value of treatment or intervention, and the harm it causes to the patient\(^{16}\). Until recently, the extent of such harm has been underestimated. In industrialized countries, approximately 1 in 10 patients suffers harm caused by avoidable adverse events while receiving care\(^{17}\); up to 98 000 deaths per year are caused by such events in the United States alone\(^{18}\).

Multiple factors contribute to this situation\(^{19}\), ranging from systemic faults to problems of competence, social pressure on patients to undergo risky procedures, to incorrect technology usage\(^{20}\). For example, almost 40% of the 16 billion injections administered worldwide each year are given with syringes and needles that are reused without sterilization\(^{21}\). Each year, unsafe injections thus cause 1.3 million deaths and almost 26 million years of life lost, mainly because of transmission of hepatitis B and C, and HIV\(^{22}\).

Especially disquieting is the paucity of information on the extent and determinants of unsafe care in low- and middle-income countries. With unregulated commercialization of care, weaker quality control and health resource limitations, healthcare users in low-income countries may well be even more exposed to the risk of unintended patient harm than patients in high-income countries. The World Alliance for Patient Safety\(^{22}\), among others, advocates making patients safer through systemic interventions and a change in organizational culture rather than through the denunciation of individual health-care practitioners or administrators\(^{23}\).

**Box 3.2 When supplier-induced and consumer-driven demand determine medical advice: ambulatory care in India**

“Ms. S is a typical patient who lives in urban Delhi. There are over 70 private-sector medical care providers within a 15-minute walk from her house (and virtually any household in her city). She chooses the private clinic run by Dr. SM and his wife. Above the clinic a prominent sign says “Ms. MM, Gold Medalist, MBBS”, suggesting that the clinic is staffed by a highly proficient doctor (an MBBS is the basic degree for a medical doctor as in the British 2 system). As it turns out, Ms. MM is rarely at the clinic. We were told that she sometimes comes at 4 a.m. to avoid the long lines that form if people know she is there. We later discover that she has “franchised” her name to a number of different clinics. Therefore, Ms. S sees Dr. SM and his wife, both of whom were trained in traditional Ayurvedic medicine through a six-month long-distance course. The doctor and his wife sit at a small table surrounded, on one side, by a large number of bottles full of pills, and on the other, a bench with patients on them, which extends into the street. Ms. S sits at the end of this bench. Dr. SM and his wife are the most popular medical care providers in the neighbourhood, with more than 200 patients every day. The doctor spends an average of 3.5 minutes with each patient, asks 3.2 questions, and performs an average of 2.5 examinations. Following the diagnosis, the doctor takes two or three different pills, crushes them using a mortar and pestle, and makes small paper packets from the resulting powder which he gives to Ms. S and asks her to take for two or three days. These medicines usually include one antibiotic and one analgesic and anti-inflammatory drug. Dr. SM tells us that he constantly faces unrealistic patient expectations, both because of the high volume of patients and their demands for treatments that even Dr. SM knows are inappropriate. Dr. SM and his wife seem highly motivated to provide care to their patients and even with a very crowded consultation room they spend more time with their patients than a public sector doctor would. However, they are not bound by their knowledge […] and instead deliver health care like the crushed pills in a paper packet, which will result in more patients willing to pay more for their services”\(^{24}\).
not enough. How services deal with people is also vitally important. Surveys in Australia, Canada, Germany, New Zealand, the United Kingdom and the United States show that a high number of patients report safety risks, poor care coordination and deficiencies in care for chronic conditions\(^{25}\). Communication is often inadequate and lacking in information on treatment schedules. Nearly one in every two patients feels that doctors only rarely or never asked their opinion about treatment. Patients may consult different providers for related or even for the same conditions which, given the lack of coordination among these providers, results in duplication and contradictions\(^{25}\). This situation is similar to that reported in other countries, such as Ethiopia\(^{26}\), Pakistan\(^{27}\) and Zimbabwe\(^{28}\).

There has, however, been progress in recent years. In high-income countries, confrontation with chronic disease, mental health problems, multi-morbidity and the social dimension of disease has focused attention on the need for more comprehensive and person-centred approaches and continuity of care. This resulted not only from client pressure, but also from professionals who realized the critical importance of such

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**Figure 3.2** Lost opportunities for prevention of mother-to-child transmission of HIV (MTCT) in Côte d’Ivoire\(^{29}\): only a tiny fraction of the expected transmissions are actually prevented

- 462 mother-to-child transmissions of HIV (expected among 11,582 pregnant women)

- 12 mother-to-child transmissions successfully prevented

- 450 failures to prevent transmission

- Lack of coverage: 77 lost
- Bad communication: 107 lost
- Lack of follow-up: 153 lost
- Access to drugs: 40 lost
- Treatment ineffective: 23 lost
features of care in achieving better outcomes for their patients. Many health professionals have begun to appreciate the limitations of narrow clinical approaches, for example, to cardiovascular disease. As a result there has been a welcome blurring of the traditional boundaries between curative care, preventive medicine and health promotion.

In low-income countries, this evolution is also visible. In recent years, many of the programmes targeting infectious disease priorities have given careful consideration to comprehensiveness, continuity and patient-centredness. Maternal and child health services have often been at the forefront of these attempts, organizing a continuum of care and a comprehensive approach. This process has been consolidated through the joint UNICEF/WHO Integrated Management of Childhood Illness initiatives. Their experience with programmes such as the WHO’s Extended Programme for Immunization has put health professionals in many developing countries a step ahead compared to their high-income country colleagues, as they more readily see themselves responsible not just for patients, but also for population coverage. More recently, HIV/AIDS programmes have drawn the attention of providers and policy-makers to the importance of counselling, continuity of care, the complementarity of prevention, treatment and palliation and critically, to the value of empathy and listening to patients.

Understanding people: person-centred care

When people are sick they are a great deal less concerned about managerial considerations of productivity, health targets, cost-effectiveness and rational organization than about their own predicament. Each individual has his or her own way of experiencing and coping with health problems within their specific life circumstances. Health workers have to be able to handle that diversity. For health workers at the interface between the population and the health services, the challenge is much more complicated than for a specialized referral service: managing a well-defined disease is a relatively straightforward technical challenge. Dealing with health problems, however, is complicated as people need to be understood holistically: their physical, emotional and social concerns, their past and their future, and the realities of the world in which they live. Failure to deal with the whole person in their specific familial and community contexts misses out on important aspects of health that do not immediately fit into disease categories. Partner violence against women (Box 3.3), for example, can be detected, prevented or mitigated by health services that are sufficiently close to the communities they serve and by health workers who know the people in their community.

People want to know that their health worker understands them, their suffering and the constraints they face. Unfortunately, many providers neglect this aspect of the therapeutic relation, particularly when they are dealing with disadvantaged groups. In many health services, responsiveness and person-centredness are treated as luxury goods to be handed out only to a selected few.

Over the last 30 years, a considerable body of research evidence has shown that person-centredness is not only important to relieve the patient’s anxiety but also to improve the provider’s job satisfaction. The response to a health problem is more likely to be effective if the provider understands its various dimensions. For a start, simply asking patients how they feel about their illness, how it affects their lives, rather than focusing only on the disease, results in measurably increased trust and compliance that allows patient and provider to find a common ground on clinical management, and facilitates the integration of prevention and health promotion in the therapeutic response. Thus, person-centredness becomes the “clinical method of participatory democracy”, measurably improving the quality of care, the success of treatment and the quality of life of those benefiting from such care.

In practice, clinicians rarely address their patients’ concerns, beliefs and understanding of illness, and seldom share problem management options with them. They limit themselves to simple technical prescriptions, ignoring the complex human dimensions that are critical to the appropriateness and effectiveness of the care they provide.
Chapter 3. Primary care: putting people first

Thus, technical advice on lifestyle, treatment schedule or referral all too often neglects not only the constraints of the environment in which people live, but also their potential for self-help in dealing with a host of health problems ranging from diarrhoeal disease\(^60\) to diabetes management\(^61\). Yet, neither the nurse in Niger’s rural health centre nor the general practitioner in Belgium can, for example, refer a patient to hospital without negotiating\(^62,63\): along with medical criteria, they have to take into account the patient’s values, the family’s values, and their lifestyle and life perspective\(^64\).

Few health providers have been trained for person-centred care. Lack of proper preparation is compounded by cross-cultural conflicts, social stratification, discrimination and stigma\(^63\). As a consequence, the considerable potential of people to contribute to their own health through lifestyle, behaviour and self-care, and by adapting...
professional advice optimally to their life circumstances is underutilized. There are numerous, albeit often missed, opportunities to empower people to participate in decisions that affect their own health and that of their families (Box 3.4). They require health-care providers who can relate to people and assist them in making informed choices. The current payment systems and incentives in community health-care delivery often work against establishing this type of dialogue. Conflicts of interest between provider and patient, particularly in unregulated commercial settings, are a major disincentive to person-centred care. Commercial providers may be more courteous and client-friendly than in the average health centre, but this is no substitute for person-centredness.

### Comprehensive and integrated responses

The diversity of health needs and challenges that people face does not fit neatly into the discrete diagnostic categories of textbook promotive, preventive, curative or rehabilitative care. They call for the mobilization of a comprehensive range of resources that may include health promotion and prevention interventions as well as diagnosis and treatment or referral, chronic or long-term home care, and, in some models, social services. It is at the entry point of the system, where people first present their problem, that the need for a comprehensive and integrated offer of care is most critical.

Comprehensiveness makes managerial and operational sense and adds value (Table 3.3). People take up services more readily if they know a comprehensive spectrum of care is on offer. Moreover, it maximizes opportunities for preventive care and health promotion while reducing unnecessary reliance on specialized or hospital care. Specialization has its comforts, but the fragmentation it induces is often visibly counter-productive and inefficient: it makes no sense to monitor the growth of children and neglect the health of their mothers (and vice versa), or to treat someone’s tuberculosis without considering their HIV status or whether they smoke.

#### Box 3.4 Empowering users to contribute to their own health

Families can be empowered to make choices that are relevant to their health. Birth and emergency plans, for example, are based on a joint examination between the expectant mother and health staff — well before the birth — of her expectations regarding childbirth. Issues discussed include where the birth will take place, and how support for care of the home and any other children will be organized while the woman is giving birth. The discussion can cover planning for expenses, arrangements for transport and medical supplies, as well as identification of a compatible blood donor in case of haemorrhage. Such birth plans are being implemented in countries as diverse as Egypt, Guatemala, Indonesia, the Netherlands and the United Republic of Tanzania. They constitute one example of how people can participate in decisions relating to their health in a way that empowers them. Empowerment strategies can improve health and social outcomes through several pathways; the condition for success is that they are embedded in local contexts and based on a strong and direct relationship between people and their health workers. The strategies can relate to a variety of areas, as shown below:

- Developing household capacities to stay healthy, make healthy decisions and respond to emergencies — France’s self-help organization of diabetics, South Africa’s family empowerment and parent training programmes, the United Republic of Tanzania’s negotiated treatment plans for safe motherhood, and Mexico’s active ageing programme;
- Increasing citizens’ awareness of their rights, needs and potential problems — Chile’s information on entitlements and Thailand’s Declaration of Patients’ Rights;
- Strengthening linkages for social support within communities and with the health system — support and advice to family caregivers dealing with dementia in developing country settings, Bangladesh’s rural credit programmes and their impact on care-seeking behaviour, and Lebanon’s neighbourhood environment initiatives.

#### Table 3.3 Comprehensiveness: evidence of its contribution to quality of care and better outcomes

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<tr>
<td>Increased uptake of disease-focused preventive care (e.g. blood pressure screen, mammograms, pap smears)</td>
<td>Bindman (1996)³⁵</td>
</tr>
<tr>
<td>Fewer patients admitted for preventable complications of chronic conditions</td>
<td>Shea (1992)³⁶</td>
</tr>
</tbody>
</table>
That does not mean that entry-point health workers should solve all the health problems that are presented there, nor that all health programmes always need to be delivered through a single integrated service-delivery point. Nevertheless, the primary-care team has to be able to respond to the bulk of health problems in the community. When it cannot do so, it has to be able to mobilize other resources, by referring or by calling for support from specialists, hospitals, specialized diagnostic and treatment centres, public-health programmes, long-term care services, home-care or social services, or self-help and other community organizations. This cannot mean giving up responsibility: the primary-care team remains responsible for helping people to navigate this complex environment.

Comprehensive and integrated care for the bulk of the assorted health problems in the community is more efficient than relying on separate services for selected problems, partly because it leads to a better knowledge of the population and builds greater trust. One activity reinforces the other. Health services that offer a comprehensive range of services increase the uptake and coverage of, for example, preventive programmes, such as cancer screening or vaccination (Figure 3.3). They prevent complications and improve health outcomes.

Comprehensive services also facilitate early detection and prevention of problems, even in the absence of explicit demand. There are individuals and groups who could benefit from care even if they express no explicit spontaneous demand, as in the case of women attending the health centres in Ouallam district, Niger, or people with undiagnosed high blood pressure or depression. Early detection of disease, preventive care to reduce the incidence of poor health, health promotion to reduce risky behaviour, and addressing social and other determinants of health all require the health service to take the initiative. For many problems, local health workers are the only ones who are in a position to effectively address problems in the community: they are the only ones, for example, in a position to assist parents with care in early childhood development, itself an important determinant of later health, well-being and productivity. Such interventions require proactive health teams offering a comprehensive range of services. They depend on a close and trusting relationship between the health services and the communities they serve, and, thus, on health workers who know the people in their community.

**Continuity of care**

Understanding people and the context in which they live is not only important in order to provide a comprehensive, person-centred response, it also conditions continuity of care. Providers often behave as if their responsibility starts when a patient walks in and ends when they leave the premises. Care should not, however, be limited to the moment a patient consults nor be confined to the four walls of the consultation room. Concern for outcomes mandates a consistent and coherent approach to the management of the patient’s problem, until the problem is resolved or the risk that justified follow-up has disappeared. Continuity of care is an important determinant of effectiveness, whether for chronic disease management, reproductive health, mental health or for making sure children grow up healthily (Table 3.4).

**Figure 3.3** More comprehensive health centres have better vaccination coverage

<table>
<thead>
<tr>
<th>DPT3 vaccination coverage (%)</th>
<th>Facility performance score</th>
</tr>
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<tbody>
<tr>
<td>Democratic Republic of the Congo</td>
<td>0.20% health centres with lowest overall performance</td>
</tr>
<tr>
<td>Madagascar</td>
<td>0.80% health centres with lowest overall performance</td>
</tr>
<tr>
<td>Rwanda</td>
<td>0.10% health centres with highest overall performance</td>
</tr>
</tbody>
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* Total 1227 health centres, covering a population of 16 million people.

* Vaccination coverage was not included in the assessment of overall health-centre performance across a range of services.

* Includes vaccination of children not belonging to target population.
capitation or by fee-for-episode, out-of-pocket fee-for-service payment is a common deterrent, not only to access, but also to continuity of care. In Singapore, for example, patients were formerly not allowed to use their health savings account (Medisave) for outpatient treatment, resulting in patient delays and lack of treatment compliance for the chronically ill. This had become so problematic that regulations were changed. Hospitals are now encouraged to transfer patients with diabetes, high blood pressure, lipid disorder and stroke to registered general practitioners, with Medisave accounts covering ambulatory care.

Other barriers to continuity include treatment schedules requiring frequent clinic attendance that carry a heavy cost in time, travel expenses or lost wages. They may be ill-understood and patient motivation may be lacking. Patients may get lost in the complicated institutional environment of referral hospitals or social services. Such problems need to be anticipated and recognized at an early stage. The effort required from health workers is not negligible: negotiating the modalities of the treatment schedule with the patients so as to maximize the chances that it can be completed; keeping registries of clients with chronic conditions; and creating communication channels through home visits, liaison with community workers, telephonic reminders and text messages to re-establish interrupted continuity. These mundane tasks often make the difference between a successful outcome and a treatment failure, but are rarely rewarded. They are much easier to implement when patient and caregiver have clearly identified how and by whom follow-up will be organized.

A regular and trusted provider as entry point

Comprehensiveness, continuity and person-centredness are critical to better health outcomes. They all depend on a stable, long-term, personal relationship (a feature also called “longitudinality”) between the population and the professionals who are their entry point to the health system.

Most ambulatory care in conventional settings is not organized to build such relationships. The
busy, anonymous and technical environment of hospital outpatient departments, with their many specialists and sub-specialists, produce mechanical interactions between nameless individuals and an institution – not people-centred care. Smaller clinics are less anonymous, but the care they provide is often more akin to a commercial or administrative transaction that starts and ends with the consultation than to a responsive problem-solving exercise. In this regard, private clinics do not perform differently than public health centres. In the rural areas of low-income countries, governmental health centres are usually designed to work in close relationship with the community they serve. The reality is often different. Earmarking of resources and staff for selected programmes is increasingly leading to fragmentation, while the lack of funds, the pauperization of the health staff and rampant commercialization makes building such relationships difficult. There are many examples to the contrary, but the relationship between providers and their clients, particularly the poorer ones, is often not conducive to building relationships of understanding, empathy and trust.

Building enduring relationships requires time. Studies indicate that it takes two to five years before its full potential is achieved, but, as the Alaska health centre mentioned at the beginning of this chapter shows, it drastically changes the way care is being provided. Access to the same team of health-care providers over time fosters the development of a relationship of trust between the individual and their health-care provider. Health professionals are more likely to respect and understand patients they know.

**Box 3.5 Using information and communication technologies to improve access, quality and efficiency in primary care**

Information and communication technologies enable people in remote and underserved areas to have access to services and expertise otherwise unavailable to them, especially in countries with uneven distribution or chronic shortages of physicians, nurses and health technicians or where access to facilities and expert advice requires travel over long distances. In such contexts, the goal of improved access to health care has stimulated the adoption of technology for remote diagnosis, monitoring and consultation. Experience in Chile of immediate transmission of electrocardiograms in cases of suspected myocardial infarction is a noteworthy example: examination is carried out in an ambulatory setting and the data are sent to a national centre where specialists confirm the diagnosis via fax or e-mail. This technology-facilitated consultation with experts allows rapid response and appropriate treatment where previously it was unavailable. The Internet is a key factor in its success, as is the telephone connectivity that has been made available to all health facilities in the country.

A further benefit of using information and communication technologies in primary-care services is the improved quality of care. Health-care providers are not only striving to deliver more effective care, they are also striving to deliver safer care. Tools, such as electronic health records, computerized prescribing systems and clinical decision aids, support practitioners in providing safer care in a range of settings. For example, in a village in western Kenya, electronic health records integrated with laboratory, drug procurement and reporting systems have drastically reduced clerical labour and errors, and have improved follow-up care.

As the costs of delivering health care continue to rise, information and communication technologies provide new avenues for personalized, citizen-centred and home-centred care. Towards this end, there has been significant investment in research and development of consumer-friendly applications. In Cape Town, South Africa, an “on cue compliance service” takes the names and mobile telephone numbers of patients with tuberculosis (supplied by a clinic) and enters them into a database. Every half an hour, the on cue server reads the database and sends personalized SMS messages to the patients, reminding them to take their medication. The technology is low-cost and robust. Cure and completion rates are similar to those of patients receiving clinic-based DOTS, but at lower cost to both clinic and patient, and in a way that interferes much less with everyday life than the visits to the clinic. In the same concept of supporting lifestyles linked to primary care, network devices have become a key element of an innovative community programme in the Netherlands, where monitoring and communication devices are built into smart apartments for senior citizens. This system reduces clinic visits and facilitates living independently with chronic diseases that require frequent checks and adjustment of medications.

Many clinicians who want to promote health and prevent illness are placing high hopes in the Internet as the place to go for health advice to complement or replace the need to seek the advice of a health professional. New applications, services and access to information have permanently altered the relationships between consumers and health professionals, putting knowledge directly into people’s own hands.
well, which creates more positive interaction and better communication. They can more readily understand and anticipate obstacles to continuity of care, follow up on the progress and assess how the experience of illness or disability is affecting the individual’s daily life. More mindful of the circumstances in which people live, they can tailor care to the specific needs of the person and recognize health problems at earlier stages.

This is not merely a question of building trust and patient satisfaction, however important these may be. It is worthwhile because it leads to better quality and better outcomes (Table 3.5). People who use the same source of care for most of their health-care needs tend to comply better with advice given, rely less on emergency services, require less hospitalization and are more satisfied with care. Providers save consultation time, reduce the use of laboratory tests and costs, and increase uptake of preventive care. Motivation improves through the social recognition built up by such relationships. Still, even dedicated health professionals will not seize all these opportunities spontaneously.

### Organizing primary-care networks

A health service that provides entry point ambulatory care for health- and health-related problems should, thus, offer a comprehensive range of integrated diagnostic, curative, rehabilitative and palliative services. In contrast to most conventional health-care delivery models, the offer of services should include prevention and promotion as well as efforts to tackle determinants of ill-health locally. A direct and enduring relationship between the provider and the people in the community served is essential to be able to take into account the personal and social context of patients and their families, ensuring continuity of care over time as well as across services.

In order for conventional health services to be transformed into primary care, i.e. to ensure that these distinctive features get due prominence, they must reorganized. A precondition is to ensure that they become directly and permanently accessible, without undue reliance on out-of-pocket payments and with social protection offered by universal coverage schemes. But another set of arrangements is critical for the transformation of conventional care – ambulatory- and institution-based, generalist and specialist – into local networks of primary-care centres:

- bringing care closer to people, in settings in close proximity and direct relationship with the community, relocating the entry point to the health system from hospitals and specialists to close-to-client generalist primary-care centres;
- giving primary-care providers the responsibility for the health of a defined population, in its entirety: the sick and the healthy, those who choose to consult the services and those who choose not to do so;
- strengthening primary-care providers’ role as coordinators of the inputs of other levels of care by giving them administrative authority and purchasing power.

### Table 3.5 Regular entry point: evidence of its contribution to quality of care and better outcomes

<table>
<thead>
<tr>
<th>Description</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better uptake of preventive care by adolescents</td>
<td>Ryan (2001)133</td>
</tr>
<tr>
<td>Protection against over-treatment</td>
<td>Schoen (2007)134</td>
</tr>
</tbody>
</table>
Bringing care closer to the people

A first step is to relocate the entry point to the health system from specialized clinics, hospital outpatient departments and emergency services, to generalist ambulatory care in close-to-client settings. Evidence has been accumulating that this transfer carries measurable benefits in terms of relief from suffering, prevention of illness and death, and improved health equity. These findings hold true in both national and cross-national studies, even if all of the distinguishing features of primary care are not fully realized.1

Generalist ambulatory care is more likely or as likely to identify common life-threatening conditions as specialist care.141,142 Generalists adhere to clinical practice guidelines to the same extent as specialists143, although they are slower to adopt them.144,145 They prescribe fewer invasive interventions,146,147,148,149 fewer and shorter hospitalizations,127,133,149 and have a greater focus on preventive care.133,150 This results in lower overall health-care costs62 for similar health outcomes146,151,152,153,154,155 and greater patient satisfaction.125,150,156 Evidence from comparisons between high-income countries shows that higher proportions of generalist professionals working in ambulatory settings are associated with lower overall costs and higher quality rankings157. Conversely, countries that increase reliance on specialists have stagnating or declining health outcomes when measured at the population level, while fragmentation of care exacerbates user dissatisfaction and contributes to a growing divide between health and social services.157,158,159 Information on low- and middle-income countries is harder to obtain,160 but there are indications that patterns are similar. Some studies estimate that in Latin America and the Caribbean more reliance on generalist care could avoid one out of two hospital admissions161. In Thailand, generalist ambulatory care outside a hospital context has been shown to be more patient-centred and responsive as well as cheaper and less inclined to over-medicalization.162

The relocation of the entry point into the system from specialist hospital to generalist ambulatory care creates the conditions for more comprehensiveness, continuity and person-centredness. This amplifies the benefits of the relocation. It is particularly the case when services are organized as a dense network of small, close-to-client service delivery points. This makes it easier to have teams that are small enough to know their communities and be known by them, and stable enough to establish an enduring relationship. These teams require relational and organizational capacities as much as the technical competencies to solve the bulk of health problems locally.

Responsibility for a well-identified population

In conventional ambulatory care, the provider assumes responsibility for the person attending the consultation for the duration of the consultation and, in the best of circumstances, that responsibility extends to ensuring continuity of care. This passive, response-to-demand approach fails to help a considerable number of people who could benefit from care. There are people who, for various reasons, are, or feel, excluded from access to services and do not take up care even when they are in need. There are people who suffer illness but delay seeking care. Others present risk factors and could benefit from screening or prevention programmes (e.g. for cervical cancer or for childhood obesity), but are left out because they do not consult: preventive services that are limited to service users often leave out those most in need.163 A passive, response-to-demand
approach has a second untoward consequence: it lacks the ambition to deal with local determinants of ill-health – whether social, environmental or work-related. All this represents lost opportunities for generating health: providers that only assume responsibility for their customers concentrate on repairing rather than on maintaining and promoting health.

The alternative is to entrust each primary-care team with the explicit responsibility for a well-defined community or population. They can then be held accountable, through administrative measures or contractual arrangements, for providing comprehensive, continuous and person-centred care to that population, and for mobilizing a comprehensive range of support services – from promotive through to palliative. The simplest way of assigning responsibility is to identify the community served on the basis of geographical criteria – the classic approach in rural areas. The simplicity of geographical assignment, however, is deceptive. It follows an administrative, public sector logic that often has problems adapting to the emergence of a multitude of other providers. Furthermore, administrative geography may not coincide with sociological reality, especially in urban areas. People move around and may work in a different area than where they live, making the health unit closest to home actually an inconvenient source of care. More importantly, people value choice and may resent an administrative assignment to a particular health unit. Some countries find geographical criteria of proximity the most appropriate to define who fits in the population of responsibility, others rely on active registration or patient lists. The important point is not how but whether the population is well identified and mechanisms exist to ensure that nobody is left out.

Once such explicit comprehensive responsibilities for the health of a well-identified and defined population are assigned, with the related financial and administrative accountability mechanisms, the rules change.

The primary-care team has to broaden the portfolio of care it offers, developing activities and programmes that can improve outcomes, but which they might otherwise neglect. This sets the stage for investment in prevention and promotion activities, and for venturing into areas that are often overlooked, such as health in schools and in the workplace. It forces the primary-care team to reach out to and work with organizations and individuals within the community: volunteers and community health workers who act as the liaison with patients or animate grassroots community groups, social workers, self-help groups, etc.

- It forces the team to move out of the four walls of their consultation room and reach out to the people in the community. This can bring significant health benefits. For example, large-scale programmes, based on home-visits and community animation, have been shown to be effective in reducing risk factors for neonatal mortality and actual mortality rates. In the United States, such programmes have reduced neonatal mortality by 60% in some settings.

Part of the benefit is due to better uptake of effective care by people who would otherwise remain deprived. In Nepal, for example, the community dynamics of women’s groups led to the better uptake of care, with neonatal and maternal mortality lower than in control communities by 29% and 80%, respectively.

- It forces the team to take targeted initiatives, in collaboration with other sectors, to reach the excluded and the unreached and tackle broader determinants of ill-health. As Chapter 2 has shown, this is a necessary complement to establishing universal coverage and one where local health services play a vital role. The 2003 heatwave in western Europe, for example, highlighted the importance of reaching out to the isolated elderly and the dramatic consequences of failing to do so: an excess mortality of more than 50 000 people.

For people and communities, formal links with an identifiable source of care enhance the likelihood that long-term relationships will develop; that services are encouraged to pay more attention to the defining features of primary care; and that lines of communication are more intelligible. At the same time, coordination linkages can be formalized with other levels of care – specialists, hospitals or other technical services – and with social services.
The primary-care team as a hub of coordination

Primary-care teams cannot ensure comprehensive responsibility for their population without support from specialized services, organizations and institutions that are based outside the community served. In resource-constrained circumstances, these sources of support will typically be concentrated in a “first referral level district hospital”. Indeed, the classic image of a health-care system based on PHC is that of a pyramid with the district hospital at the top and a set of (public) health centres that refer to the higher authority.

In conventional settings, ambulatory care professionals have little say in how hospitals and specialized services contribute – or fail to contribute – to the health of their patients, and feel little inclination to reach out to other institutions and stakeholders that are relevant to the health of the local community. This changes if they are entrusted with responsibility for a defined population and are recognized as the regular point of entry for that population. As health-care networks expand, the health-care landscape becomes far more crowded and pluralistic. More resources allow for diversification: the range of specialized services that comes within reach may include emergency services, specialists, diagnostic infrastructure, dialysis centres, cancer screening, environmental technicians, long-term care institutions, pharmacies, etc. This represents new opportunities, provided the primary-care teams can assist their community in making the best use of that potential, which is particularly critical to public health, mental health and long-term care.168

The coordination (or gatekeeping) role this entails effectively transforms the primary-care pyramid into a network, where the relations between the primary-care team and the other institutions and services are no longer based only on top-down hierarchy and bottom-up referral, but on cooperation and coordination (Figure 3.5). The primary-care team then becomes the mediator between the community and the other levels.

Figure 3.5 Primary care as a hub of coordination: networking within the community served and with outside partners173,174
of the health system, 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.

This coordination and mediation role also extends to collaboration with other types of organizations, often nongovernmental. These can provide significant support to local primary care. They can help ensure that people know what they are entitled to and have the information to avoid substandard providers. Independent ombudsman structures or consumer organizations can help users handle complaints. Most importantly, there is a wealth of self-help and mutual support associations for diabetics, people living with handicaps and chronic diseases that can help people to help themselves. In the United States alone, more than five million people belong to mutual help groups while, in recent years, civil society organizations dealing with health and health-related issues, from self-help to patient’s rights, have been mushrooming in many low- and middle-income countries. These groups do much more than just inform patients. They help people take charge of their own situation, improve their health, cope better with ill-health, increase self-confidence and diminish over-medicalization. Primary-care teams can only be strengthened by reinforcing their linkages with such groups.

Where primary-care teams are in a position to take on this coordinator role, their work becomes more rewarding and attractive, while the overall effects on health are positive. Reliance on specialists and hospitalization is reduced by filtering out unnecessary uptake, whereas patient delay is reduced for those who do need referral care, the duration of their hospitalization is shortened, and post-hospitalization follow-up is improved.

The coordination function provides the institutional framework for mobilizing across sectors to secure the health of local communities. It is not an optional extra but an essential part of the remit of primary-care teams. This has policy implications: coordination will remain wishful thinking unless the primary-care team has some form of either administrative or financial leverage. Coordination also depends on the different institutions’ recognition of the key role of the primary-care teams. Current professional education systems, career structure and remuneration mechanisms most often give signals to the contrary. Reversing these well-entrenched disincentives to primary care requires strong leadership.

Monitoring progress

The switch from conventional to primary care is a complex process that cannot be captured in a single, universal metric. Only in recent years has it been possible to start disentangling the effects of the various features that define primary care. In part, this is because the identification of the features that make the difference between primary care and conventional health-care delivery has taken years of trial and error, and the instruments to measure them have not been generalized. This is because these features are never all put into place as a single package of reforms, but are the result of a gradual shaping and transformation of the health system. Yet, for all this complexity, it is possible to measure progress, as a complement to the follow-up required for measuring progress towards universal coverage.

The first dimension to consider is the extent to which the organizational measures required to switch to primary care are being put into place.

■ Is the predominant type of first-contact provider being shifted from specialists and hospitals to generalist primary-care teams in close proximity to where the people live?

■ Are primary-care providers being made responsible for the health of all the members of a well-identified population: those who attend health services and those who do not?

■ Are primary-care providers being empowered to coordinate the various inputs of specialized, hospital and social services, by strengthening their administrative authority and purchasing power?

The second dimension to consider is the extent to which the distinctive features of primary care are gaining prominence.

■ Person-centredness: is there evidence of improvement, as shown by direct observation and user surveys?
Comprehensiveness: is the portfolio of primary-care services expanding and becoming more comprehensive, reaching the full essential benefits package, from promotion through to palliation, for all age groups?

Continuity: is information for individuals being recorded over the life-course, and transferred between levels of care in cases of referral and to a primary-care unit elsewhere when people relocate?

Regular entry point: are measures taken to ensure that providers know their clients and vice versa?

This should provide the guidance to policy-makers as to the progress they are making with the transformation of health-care delivery. However, they do not immediately make it possible to attribute health and social outcomes to specific aspects of the reform efforts. In order to do so, the monitoring of the reform effort needs to be complemented with a much more vigorous research agenda. It is revealing that the Cochrane Review on strategies for integrating primary-health services in low- and middle-income countries could identify only one valid study that took the user’s perspective into account. There has been a welcome surge of research on primary care in high-income countries and, more recently, in the middle-income countries that have launched major PHC reforms. Nevertheless, it is remarkable that an industry that currently mobilizes 8.6% of the world’s GDP invests so little in research on two of its most effective and cost-effective strategies: primary care and the public policies that underpin and complement it.

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Public policies in the health sector, together with those in other sectors, have a huge potential to secure the health of communities. They represent an important complement to universal coverage and service delivery reforms. Unfortunately, in most societies, this potential is largely untapped and failures to effectively engage other sectors are widespread. Looking ahead at the diverse range of challenges associated with the growing importance of ageing, urbanization and the social determinants of health, there is, without question, a need for a greater capacity to seize this potential. That is why a drive for better public policies – the theme of this chapter – forms a third pillar supporting the move towards PHC, along with universal coverage and primary care.
The chapter reviews the policies that must be in place. These are:

- **systems policies** – the arrangements that are needed across health systems’ building blocks to support universal coverage and effective service delivery;
- **public-health policies** – the specific actions needed to address priority health problems through cross-cutting prevention and health promotion; and
- **policies in other sectors** – contributions to health that can be made through intersectoral collaboration.

The chapter explains how these different public policies can be strengthened and aligned with the goals pursued by PHC.

**The importance of effective public policies for health**

People want to live in communities and environments which secure and promote their health. Primary care, with universal access and social protection represent key responses to these expectations. People also expect their governments to put into place an array of public policies that span local through to supra-national level arrangements, without which primary care and universal coverage lose much of their impact and meaning. These include the policies required to make health systems function properly; to organize public-health actions of major benefit to all; and, beyond the health sector, the policies that can contribute to health and a sense of security, while ensuring that issues, such as urbanization, climate change, gender discrimination or social stratification are properly addressed.

A first group of critical public policies are the health systems policies (related to essential drugs, technology, quality control, human resources, accreditation, etc.) on which primary care and universal coverage reforms depend. Without functional supply and logistics systems, for example, a primary-care network cannot function properly: in Kenya, for example, children are now much better protected against malaria as a result of local services providing them with insecticide-treated bednets. This has only been possible because the work of primary care was supported by a national initiative with strong political commitment, social marketing and national support for supply and logistics.

Effective public-health policies that address priority health problems are a second group without which primary care and universal coverage reforms would be hindered. These encompass the technical policies and programmes that provide guidance to primary-care teams on how to deal with priority health problems. They also encompass the classical public-health interventions, from public hygiene and disease prevention to health promotion. Some interventions, such as the fortification of salt with iodine, are only feasible at the regional, national or, increasingly at supra-national level. This may be because it is only at those levels that there is the necessary authority to decide upon such policies, or because it is more efficient to develop and implement such policies on a scale that is beyond the local dimensions of primary-care action. Finally, public policies encompass the rapid response capacity, in command-and-control mode, to deal with acute threats to the public’s health, particularly epidemics and catastrophes. The latter is of utmost political importance, because failures profoundly affect the public’s trust in its health authorities. The lack of preparedness and uncoordinated responses of both the Canadian and the Chinese health systems to the outbreak of SARS in 2003, led to public outcries and eventually to the establishment of a national public health agency in Canada. In China, a similar lack of preparedness and transparency led to a crisis in confidence – a lesson learned in time for subsequent events.

The third set of policies that is of critical concern is known as “health in all policies”, which is based on the recognition that population health can be improved through policies that are mainly controlled by sectors other than health. The health content of school curricula, industry’s policy towards gender equality, or the safety of food and consumer goods are all issues that can profoundly influence or even determine the health of entire communities, and that can cut across national boundaries. It is not possible to address such issues without intensive intersectoral collaboration that gives due weight to health in all policies.
Chapter 4. Public policies for the public’s health

Better public policies can make a difference in very different ways. They can mobilize the whole of society around health issues, as in Cuba (Box 4.1). They can provide a legal and social environment that is more or less favourable to health outcomes. The degree of legal access to abortion, for example, co-determines the frequency and related mortality of unsafe abortion⁶. In South Africa, a change in legislation increased women’s access to a broad range of options for the prevention and treatment of unwanted pregnancy, resulting in a 91% drop in abortion-related deaths⁷. Public policies can anticipate future problems. In Bangladesh, for example, the death toll due to high intensity cyclones and flooding was 240,000 people in 1970. With emergency preparedness and multisectoral risk reduction programmes, the death toll of comparable or more severe storms was reduced to 138,000 people in 1991 and 4500 people in 2007⁸,⁹,¹⁰.

In the 23 developing countries that comprise 80% of the global chronic disease burden, 8.5 million lives could be saved in a decade by a 15% dietary salt reduction through manufacturers voluntarily reducing salt content in processed foods and a sustained mass-media campaign encouraging dietary change. Implementation of four measures from the Framework Convention on Tobacco Control (increased tobacco taxes; smoke-free workplaces; convention-compliant packaging, labelling and awareness campaigns about health risks; and a comprehensive advertising, promotion, and sponsorship ban) could save a further 5.5 million lives in a decade¹¹. As is often the case when considering social, economic and political determinants of ill-health, improvements are dependent on a fruitful collaboration between the health sector and a variety of other sectors.

Figure 4.1 Deaths attributable to unsafe abortion per 100,000 live births, by legal grounds for abortion¹²,¹³

<table>
<thead>
<tr>
<th>Grounds for Abortion</th>
<th>Deaths Attributable to Unsafe Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>To save the women’s life only, or no grounds</td>
<td>&gt; 200</td>
</tr>
<tr>
<td>Also to preserve health</td>
<td>200</td>
</tr>
<tr>
<td>Also in cases of rape or incest</td>
<td>150</td>
</tr>
<tr>
<td>Also in cases of fetal impairment</td>
<td>100</td>
</tr>
<tr>
<td>Also for economic or social reasons</td>
<td>50</td>
</tr>
<tr>
<td>Also on request</td>
<td>0</td>
</tr>
</tbody>
</table>

Box 4.1 Rallying society’s resources for health in Cuba¹⁴,¹⁵,¹⁶

In Cuba, average life expectancy at birth is the second highest in the Americas: in 2006, it was 78 years, and only 7.1 per 1000 children died before the age of five. Educational indicators for young children are among the best in Latin America. Cuba has achieved these results despite significant economic difficulties – even today, GDP per capita is only US 4500. Cuba’s success in ensuring child welfare reflects its commitment to national public-health action and intersectoral action.

The development of human resources for health has been a national priority. Cuba has a higher proportion of doctors in the population than any other country. Training for primary care gives specific attention to the social determinants of health. They work in multidisciplinary teams in comprehensive primary-care facilities, where they are accountable for the health of a geographically defined population providing both curative and preventive services. They work in close contact with their communities, social services and schools, reviewing the health of all children twice a year with the teachers. They also work with organizations such as the Federation of Cuban Women (FMC) and political structures. These contacts provide them with the means to act on the social determinants of health within their communities.

Cuban national policy has also prioritized investing in early child development. There are three non-compulsory preschool education programmes, which together are taken up by almost 100% of children under six years of age. In these programmes, screening for developmental disorders facilitates early intervention. Children who are identified with special needs, and their families, receive individual attention through multidisciplinary teams that contain both health and educational specialists. National policy in Cuba has not succumbed to a false choice between investing in the medical workforce and acting on the social determinants of health. Instead, it has promoted intersectoral cooperation to improve health through a strong preventive approach. In support of this policy, a large workforce has been trained to be competent in clinical care, working as an active part of the community it serves.

*Every dot represents one country.*
System policies that are aligned with PHC goals

There is growing awareness that when parts of the health system malfunction, or are misaligned, the overall performance suffers. Referred to variously as “core functions”\(^\text{17}\) or “building blocks”\(^\text{18}\), the components of health systems include infrastructure, human resources, information, technologies and financing – all with consequences for the provision of services. These components are not aligned naturally or simply with the intended direction of PHC reforms that promote primary care and universal coverage: to obtain that alignment requires deliberate and comprehensive policy arrangements.

Experience in promoting essential medicines has shed light on both the opportunities and obstacles to effective systems policies for PHC. Since the \textit{WHO List of Essential Medicines} was established in 1977, it has become a primary stimulus to the development of national medicines policies. Over 75% of the 193 WHO Member States now claim to have a national list of essential medicines, and over 100 countries have developed a national medicine policy. Surveys reveal that these policies have been effective in making lower cost and safer medicines available and more rationally used\(^\text{19,20}\). This particular policy has been successfully designed to support PHC, and it offers lessons on how to handle cross-cutting challenges of scale efficiencies and systems co-dependence. Without such arrangements, the health costs are enormous: nearly 30,000 children die every day from diseases that could easily have been treated if they had had access to essential medicines\(^\text{21}\).

Medicines policies are indicative of how efficiencies in the scale of organization can be tapped. Safety, efficacy and quality of care have universal properties that make them amenable to globally agreed international standards. Adoption and adaptation of these global standards by national authorities is much more efficient than each country inventing its own standards. National decision-making and purchasing mechanisms can then guide rational, cost-effectiveness-based selection of medicines and reduce costs through bulk purchase. For example, Figure 4.2 shows how centralized oversight of drug purchasing and subsidy in New Zealand significantly improved access to essential medicines while lowering the average prescription price. On a larger scale, transnational mechanisms, such as UNICEF’s international procurement of vaccines, PAHO’s Revolving Fund and the Global Drug Facility for tuberculosis treatment, afford considerable savings as well as quality assurances that countries on their own would be unlikely to negotiate\(^\text{22,23,24,25}\).

A second key lesson of experience with essential drugs policies is that a policy cannot exist as an island and expect to be effectively implemented. Its formulation must identify those other systems elements, be they financing, information, infrastructure or human resources, upon which its implementation is dependent. Procurement mechanisms for pharmaceuticals, for example, raise important considerations for systems financing policies: they are interdependent. Likewise, human resources issues related to the education of consumers as well as the training and working conditions of providers are likely to be key determinants of the rational use of drugs.

Systems policies for human resources have long been a neglected area and one of the main constraints to health systems development\(^\text{27}\). The realization that the health MDGs are contingent on bridging the massive health-worker shortfall in low-income countries has brought long overdue attention to a previously neglected area. Furthermore, the evidence of increasing dependence on migrant health workers to address shortages in OECD countries underlines the fact that one country’s policies may have a significant impact on another’s. The choices countries make – or fail to

\textbf{Figure 4.2 Annual pharmaceutical spending and number of prescriptions dispensed in New Zealand since the Pharmaceutical Management Agency was convened in 1993}\(^\text{26}\)
make – can have major long-term consequences. Human resources for health are the indispensable input to effective implementation of primary care and universal coverage reforms, and they are also the personification of the values that define PHC. Yet, in the absence of a deliberate choice to guide the health workforce policy by the PHC goals, market forces within the health-care system will drive health workers towards greater sub-specialization in tertiary care institutions, if not towards migration to large cities or other countries. PHC-based policy choices, on the other hand, focus on making staff available for the extension of coverage to underserved areas and disadvantaged population groups, as with Malaysia’s scaling up of 11 priority cadres of workers, Ethiopia’s training of 30,000 Health Extension Workers, Zambia’s incentives to health workers to serve in rural areas, the 80,000 Lady Health Workers in Pakistan, or the task shifting for the care of HIV patients. These policies direct investments towards the establishment of the primary-care teams that are to be the hub of the PHC-based health system: the 80,000 health workers for Brazil’s 30,000 Family Health Teams or the retraining of over 10,000 nurses and physicians in Turkey. Furthermore, these policies require both financial and non-financial incentives to compete effectively for scarce human resources, as in the United Kingdom, where measures have been taken to make a career in primary care financially competitive with specialization.

The core business of ministries of health and other public authorities is to put into place, across the various building blocks of the health system, the set of arrangements and mechanisms required to meet their health goals. When a country chooses to base its health systems on PHC – when it starts putting into place primary care and universal coverage reforms – its whole arsenal of system policies needs to be aligned behind these reforms: not just those pertaining to service delivery models or financing. It is possible to develop system policies that do not take account of the PHC agenda. It is also possible to choose to align them to PHC. If a country opts for PHC, effective implementation allows no half measures; no health systems building block will be left untouched.

Public-health policies

Aligning priority health programmes with PHC

Much action in the health sector is marshalled around specific high-burden diseases, such as HIV/AIDS, or stages of the life course such as children – so-called priority health conditions. The health programmes that are designed around these priorities are often comprehensive insofar as they set norms, ensure visibility and quality assurance, and entail a full range of entry points to address them locally or at the level of countries or regions. Responses to these priority health conditions can be developed in ways that either strengthen or undercut PHC.

In 1999 for example, the Primary Care Department of the Brazilian Paediatrics Society (SBP) prepared a plan to train its members in the Integrated Management of Childhood Illness (IMCI) and to adapt this strategy to regional epidemiological characteristics. Despite conducting an initial training course, the SBP then warned paediatricians that IMCI was not a substitute for traditional paediatric care and risked breaching the basic rights of children and adolescents. In a next step, it objected to the delegation of tasks to the nurses, who are part of the multidisciplinary family health teams, the backbone of Brazil’s PHC policy. Eventually, the SBP attempted to reclaim child and adolescent care as the exclusive domain of paediatricians with the argument that this ensured the best quality of care.

Experience with priority health programmes shows that the way they are designed makes the difference: trying to construct an entire set of PHC reforms around the unique requirements of a single disease leads to considerable inefficiencies. Yet, the reverse is equally true. While AIDS has been referred to as a metaphor for all that ails health systems and the wider society, the global response to the HIV pandemic can, in many respects, also be viewed as a pathfinder for PHC. From the start, it has had a strong rights-based and social justice foundation. Its links to often marginalized and disadvantaged high-risk constituencies, and concerns about stigma, have led to concerted efforts to secure their rights and entitlements to employment, social services and
health care. Efforts to scale-up services to conform to the goals of universal access have helped to expose the critical constraints deriving from the workforce crisis. The challenge of providing life-long treatment in resource-constrained settings has inspired innovations, such as more effective deployment of scarce human resources via “task shifting”, the use of “patient advocates” and the unexpected implementation of electronic health records. Most importantly, the adoption of a continuum of care approaches for HIV/AIDS from prevention to treatment to palliation has helped to revive and reinforce core features of primary care, such as comprehensiveness, continuity and person-centredness.

**Countrywide public-health initiatives**

While it is essential that primary-care teams seek to improve the health of populations at local level, this may be of limited value if national- and global-level policy-makers fail to take initiatives for broader, public policy measures, which are important in changing nutrition patterns and influencing the social determinants of health. These can rarely be implemented only in the context of local policies. Classical areas in which beyond-local-scale public-health interventions may be beneficial include: altering individual behaviours and lifestyles; controlling and preventing disease; tackling hygiene and the broader determinants of health; and secondary prevention, including screening for disease. This includes measures such as the fortification of bread with folate, taxation of alcohol and tobacco, and ensuring the safety of food, consumer goods and toxic substances. Such national- and transnational-scale public-health interventions have the potential to save millions of lives. The successful removal of the major risk factors of disease, which is technically possible, would reduce premature deaths by an estimated 47% and increase global healthy life expectancy by an estimated 9.3 years. However, as is the case for the priority programmes discussed above, the corresponding public-health policies must be designed so as to reinforce the PHC reforms.

Not all such public-health interventions will improve, for example, equity. Health promotion efforts that target individual risk behaviours, such as health education campaigns aimed at smoking, poor nutrition and sedentary lifestyles, have often inadvertently exacerbated inequalities. Socioeconomic differences in the uptake of one-size-fits-all public-health interventions have, at times, not only resulted in increased health inequalities, but also in victim-blaming to explain the phenomenon. Well-designed public-health policies can, however, reduce inequalities when they provide health benefits to entire populations or when they explicitly prioritize groups with poor health. The evidence base for privileging public policies that reduce inequalities is increasing, most notably through the work of the Commission on Social Determinants of Health (Box 4.2).

**Rapid response capacity**

While PHC reforms emphasize the importance of participatory and deliberative engagement of diverse stakeholders, humanitarian disasters or disease outbreaks demand a rapid response capacity that is crucial in dealing effectively with the problem at hand and is an absolute imperative in maintaining the trust of the population in their health system. Invoking quarantines or travel bans, rapidly sequencing the genome of a new pathogen to inform vaccine or therapeutic design, and mobilizing health workers and institutions without delay can be vital. While the advent of an “emergency” often provides the necessary good will and flexibility of these diverse actors to respond, an effective response is more likely if there have been significant investments in preparedness.

Global efforts related to the threat of pandemic avian influenza (H5N1) provide a number of interesting insights into how policies that inform preparedness and response could be guided by the values of PHC related to equity, universal coverage and primary-care reforms. In dealing with seasonal and pandemic influenza, 116 national influenza laboratories, and five international collaborating centre laboratories share influenza viruses in a system that was started by WHO over 50 years ago. The system was implemented to identify new pandemic virus threats and inform the optimal annual preparation of a seasonal influenza vaccine that is used primarily by industrialized countries. With the primarily
developing country focus of human zoonotic infections and the spectre of a global pandemic associated with H5N1 strains of influenza, the interest in influenza now extends to developing countries, and the long-standing public-private approach to influenza vaccine production and virus sharing has come under intense scrutiny. The expectation of developing countries for equitable access to protection, including affordable access to anti-virals and vaccines in the event of a pandemic, is resulting in changes to national and global capacity strengthening: from surveillance and laboratories to capacity transfer for vaccine formulation and production, and capacity for stock-piling. Thus, the most equitable response is the most effective response, and the most effective rapid response capacity can only emerge from the engagement of multiple stakeholders in this global process of negotiation.

Towards health in all policies
The health of populations is not merely a product of health sector activities – be they primary-care action or countrywide public-health action. It is to a large extent determined by societal and economic factors, and hence by policies and actions that are not within the remit of the health sector. Changes in the workplace, for example, can have a range of consequences for health (Table 4.1).

Confronted with these phenomena, the health authorities may perceive the sector as powerless to do more than try to mitigate the consequences. It cannot, of itself, redefine labour relations or unemployment arrangements. Neither can it increase taxes on alcohol, impose technical norms on motor vehicles or regulate rural migration and the development of slums – although all these measures can yield health benefits. Good urban governance, for example, can lead to 75 years or more of life expectancy, against as few as 35 years with poor governance. Thus, it is important for the health sector to engage with other sectors, not just in order to obtain collaboration on tackling pre-identified priority health problems, as is the case for well-designed public-health interventions, but to ensure that health is recognized as one of the socially valued outcomes of all policies.

Such intersectoral action was a fundamental principle of the Alma-Ata Declaration. However, ministries of health in many countries have struggled to coordinate with other sectors or wield influence beyond the health system for which they are formally responsible. A major obstacle to reaping the rewards of intersectoral action has been the tendency, within the health sector, to see such collaboration as "mostly symbolic in trying to get other sectors to help [health] services." Intersectoral action has often not concentrated

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Box 4.2 Recommendations of the Commission on Social Determinants of Health

The Commission on Social Determinants of Health (CSDH) was a three-year effort begun in 2005 to provide evidence-based recommendations for action on social determinants to reduce health inequities. The Commission accumulated an unprecedented collection of material to guide this process, drawing from theme-based knowledge networks, civil society experiences, country partners and departments within WHO. The final report of the CSDH contains a detailed series of recommendations for action, organized around the following three overarching recommendations.

1. **Improve daily living conditions**
   Key improvements required in the well-being of girls and women; the circumstances in which their children are born, early child development and education for girls and boys; living and working conditions; social protection policy; and conditions for a flourishing older life.

2. **Tackle the inequitable distribution of power, money and resources**
   To address health inequities it is necessary to address inequities in the way society is organized. This requires a strong public sector that is committed, capable and adequately financed. This in turn requires strengthened governance including stronger civil society and an accountable private sector. Governance dedicated to pursuing equity is required at all levels.

3. **Measure and understand the problem and assess the impact of action**
   It is essential to acknowledge the problem of health inequity and ensure that it is measured – both within countries and globally. National and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health are required that also evaluate the health equity impact of policy and action. Other requirements are the training of policy-makers and health practitioners, increased public understanding of social determinants of health, and a stronger social determinants focus in research.
on improving the policies of other sectors, but on instrumentalizing their resources: mobilizing teachers to contribute to the distribution of bednets, police officers to trace tuberculosis treatment defaulters, or using the transport of the department of agriculture for the emergency evacuation of sick patients.

A “whole-of-government approach”, aiming for “health in all policies” follows a different logic41,42. It does not start from a specific health problem and look at how other sectors can contribute to solving them – as would be the case, for example, for tobacco-related disease. It starts by looking at the effects of agricultural, educational, environmental, fiscal, housing, transport and other policies on health. It then seeks to work with these other sectors to ensure that, while contributing to well-being and wealth, these policies also contribute to health.

Other sector’s public policies, as well as private sector policies, can be important to health in two ways.

Some may lead to adverse consequences for health (Table 4.1). Often such adverse consequences are identified retrospectively, as in the case of the negative health effects of air pollution or industrial contamination. Yet, it is also often possible to foresee them or detect them at an early stage. Decision-makers in other sectors may be unaware of the consequences

### Table 4.1 Adverse health effects of changing work circumstances

<table>
<thead>
<tr>
<th>Adverse health effects of unemployment</th>
<th>Adverse health effects of restructuring</th>
<th>Adverse health effects of non-standard work arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevated blood pressure</td>
<td>Reduced job satisfaction, reduced organizational commitment and greater stress</td>
<td>Higher rates of occupational injury and disease than workers with full-time stable employment</td>
</tr>
<tr>
<td>Increased depression and anxiety</td>
<td>Feelings of unfairness in downsizing process</td>
<td>High level of stress, low job satisfaction and other negative health and well-being factors</td>
</tr>
<tr>
<td>Increased visits to general practitioners</td>
<td>Survivor face new technologies, work processes, new physical and psychological exposures (reduced autonomy, increased work intensity, changes in the characteristics of social relationships, shifts in the employment contracts and changes in personal behaviour)</td>
<td>More common in distributive and personal service sub-sectors where people in general have lower educational attainment and low skill levels</td>
</tr>
<tr>
<td>Increased symptoms of coronary disease</td>
<td>Changes in the psychological contract and lost sense of trust</td>
<td>Low entitlement to workers’ compensation and low level of claims by those who are covered</td>
</tr>
<tr>
<td>Worse mental health and greater stress</td>
<td>Prolonged stress with physiological and psychological signs</td>
<td>Increased occupational health hazards due to work intensification motivated by economic pressures</td>
</tr>
<tr>
<td>Increased psychological morbidity and increased medical visits</td>
<td></td>
<td>Inadequate training and poor communication caused by institutional disorganization and inadequate regulatory control</td>
</tr>
<tr>
<td>Decreased self-reported health status and an increase in the number of health problems</td>
<td></td>
<td>Inability of workers to organize their own protection</td>
</tr>
<tr>
<td>Increase in family problems, particularly financial hardships</td>
<td></td>
<td>Cumulative trauma claims are difficult to show due to mobility of workers</td>
</tr>
</tbody>
</table>

- Reduced ability to improve life conditions due to inability to obtain credit, find housing, make pension arrangements, and possibility for training
- Fewer concerns for environmental issues and health and safety at work

- Lower rates of occupational injury and disease than workers with full-time stable employment
- Higher levels of stress, low job satisfaction and other negative health and well-being factors
- More common in distributive and personal service sub-sectors where people in general have lower educational attainment and low skill levels
- Low entitlement to workers’ compensation and low level of claims by those who are covered
- Increased occupational health hazards due to work intensification motivated by economic pressures
- Inadequate training and poor communication caused by institutional disorganization and inadequate regulatory control
- Inability of workers to organize their own protection
- Cumulative trauma claims are difficult to show due to mobility of workers
- Reduced ability to improve life conditions due to inability to obtain credit, find housing, make pension arrangements, and possibility for training
- Fewer concerns for environmental issues and health and safety at work
of the choices they are making, in which case engagement, with due consideration for the other sectors’ goals and objectives, may then be the first step in minimizing the adverse health effects.

Public policies developed by other sectors – education, gender equality and social inclusion – may positively contribute to health in ways that these other sectors are equally unaware of. They may be further enhanced by more purposefully pursuing these positive health outcomes, as an integral part of the policy. For example, a gender equality policy, developed in its own right, may produce health benefits, often to a degree that the proponents of the policy underestimate. By collaborating to give more formal recognition to these outcomes, the gender equality policy itself is reinforced, and the synergies enhance the health outcomes.

In that case, the objective of intersectoral collaboration is to reinforce the synergies.

Failing to collaborate with other sectors is not without its consequences. It affects the performance of health systems and, particularly, primary care. For example, Morocco’s trachoma programme relied both on high levels of community mobilization and on effective collaboration with the ministries of education, interior and local affairs. That collaboration has been the key to the successful elimination of trachoma. In contrast, the same country’s tuberculosis control programme failed to link up with urban development and poverty reduction efforts and, as a result, its performance has been disappointing.

Both were administered by the same Ministry of Health, by staff with similar capacities working under similar resource constraints, but with different strategies.

Failing to collaborate with other sectors has another consequence, which is that avoidable ill-health is not avoided. In the NGagne Diaw quarter of Thiaroye-sur-Mer, Dakar, Senegal, people make a living from the informal recycling of lead batteries. This was of little concern to the authorities until an unexplained cluster of child deaths prompted an investigation. The area was found to be contaminated with lead, and the siblings and mothers of the dead children were found to have extremely high concentrations of lead in their blood. Now, major investments are required to deal with the health and social consequences and to decontaminate the affected area, including people’s homes. Before the cluster of deaths occurred, the health sector had, unfortunately, not considered it a priority to work with other sectors to help to avoid this situation.

Where intersectoral collaboration is successful, the health benefits can be considerable, although deaths avoided are less readily noticed than lives lost. For example, pressure from civil society and professionals led to the development, in France, of a multi-pronged, high-profile strategy to improve road safety as a social and political issue that had to be confronted (and not primarily as a health sector issue). Various sectors worked together in a sustained effort, with high-level political endorsement, to reduce road-traffic accidents, with highly publicized monitoring of progress and a reduction in fatalities of up to 21% per year.

The health and health equity benefits of working towards health in all policies have become apparent in programmes such as “Healthy Cities and Municipalities”, “Sustainable Cities”, and “Cities Without Slums”, with integrated approaches that range from engagement in budget hearings and social accountability mechanisms to data gathering and environmental intervention.

In contemporary societies, health tends to become fragmented into various sub-institutions dealing with particular aspects of health or health systems, while the capacity to assemble the various aspects of public policy that jointly determine health is underdeveloped. Even in the well-resourced context of, for example, the European Union, the institutional basis for doing this remains poorly developed. Ministries of health have a vital role to play in creating such a basis, which is among the key strategies for making headway in tackling the socioeconomic determinants of ill-health.

Understanding the under-investment

Despite the benefits and low relative cost of better public policies, their potential remains largely underutilized across the world. One high-profile example is that only 5% of the world’s population live in countries with comprehensive tobacco
advertising, promotion and sponsorship bans, despite their proven efficacy in reducing health threats, which are projected to claim one billion lives this century\textsuperscript{50}.

The health sector’s approach to improving public policies has been singularly unsystematic and guided by patchy evidence and muddled decision-making – not least because the health community has put so little effort into collating and communicating these facts. For all the progress that has been made in recent years, information on the effectiveness of interventions to redress, for example, health inequities is still hard to come by and, when it is available, it is confined to a privileged circle of concerned experts. A lack of information and evidence is, thus, one of the explanations for under-investment.

Box 4.3 How to make unpopular public policy decisions\textsuperscript{57}

The Seventh Futures Forum of senior health executives organized by the World Health Organization’s Regional Office for Europe in 2004 discussed the difficulties decision-makers can have in tackling unpopular policy decisions. A popular decision is usually one that results from broad public demand; an unpopular decision does not often respond to clearly expressed public expectations, but is made because the minister or the chief medical officer knows it is the right action to bring health gains and improve quality. Thus, a potentially unpopular decision should not seek popularity but, rather, efforts must be made to render it understandable and, therefore, acceptable. Making decisions more popular is not an academic exercise but one that deals with actual endorsement. When a decision is likely to be unpopular, participants in the Forum agreed that it is advisable for health executives to apply some of the following approaches.

Talk about health and quality improvement. Health is the core area of expertise and competence, and the explanations of how the decision will improve the quality of health and health services should therefore come first. Avoiding non-health arguments that are difficult to promote may be useful – for instance, in the case of hospital closures, it is much better to talk about improving quality of care than about containing costs.

Offer compensation. Explain what people will receive to balance what they will have to give up. Offer some gains in other sectors or in other services; work to make a win-win interpretation of the coming decision by balancing good and bad news.

Be strong on implementation. If health authorities are not ready to implement the decision, they should refrain from introducing it until they are ready to do so.

Be transparent. Explain who is taking the decision and the stakes of those involved and those who are affected. Enumerate all the stakeholders and whether they [are] involved negatively.

Avoid one-shot decisions. Design and propose the decisions as part of an overall plan or strategy.

Ensure good timing. Before making a decision, it is essential to take enough time to prepare and develop a good plan. When the plan is ready, the best choice may be to act quickly for implementation.

Involving all groups. Bring into the discussion both the disadvantaged groups and the ones who will benefit from the decision. Diversify the approach.

Do not expect mass-media support solely because the decision is the right one from the viewpoint of health gains. The mass media cannot be expected to be always neutral or positive; they may often be brought into the debate by the opponents of the decision. Be prepared to face problems with the press.

Be modest. Acceptability of the decision is more likely when decision-makers acknowledge in public that there is some uncertainty about the result and they commit openly to monitoring and evaluating the outcomes. This leaves the door open for adjustments during the process of implementation.

Be ready for quick changes. Sometimes the feelings of the public change quickly and what was perceived as opposition can turn into acceptance.

Be ready for crisis and unexpected side-effects. Certain groups of populations can be especially affected by a decision (such as general practitioners in the case of hospital closures). Public-health decision-makers have to cope with reactions that were not planned.

Stick to good evidence. Public acceptance may be low without being based on any objective grounds. Having good facts is a good way to shape the debate and avoid resistance.

Use examples from other countries. Decision-makers may look at what is being done elsewhere and explain why other countries deal with a problem differently; they can use such arguments to make decisions more acceptable in their own country.

Involve health professionals and, above all, be courageous.
The fact is, however, that even for well-informed political decision-makers, many public policy issues have a huge potential for unpopularity: whether it is reducing the number of hospital beds, imposing seatbelts, culling poultry or taxing alcohol, resistance is to be expected and controversy an everyday occurrence. Other decisions have so little visibility, e.g. measures that ensure a safe food production chain, that they offer little political mileage. Consensus on stern measures may be easy to obtain at a moment of crisis, but public opinion has a notoriously short attention span. Politicians often pay more attention to policies that produce benefits within electoral cycles of two to four years and, therefore, undervalue efforts where benefits, such as those of environmental protection or early child development, accrue over a time span of 20 to 40 years. If unpopularity is one intractable disincentive to political commitment, active opposition from well-resourced lobbies is another. An obvious example is the tobacco industry’s efforts to limit tobacco control. Similar opposition is seen to the regulation of industrial waste and to the marketing of food to children. These obstacles to steering public policy are real and need to be dealt with in a systematic way (Box 4.3).

Compounding these disincentives to political commitment is the difficulty of coordinating operations across multiple institutions and sectors. Many countries have limited institutional capacity to do so and, very often, do not have enough capable professionals to cope with the work involved. Crisis management, short-term planning horizons, lack of understandable evidence, unclear intersectoral arrangements, vested interests and inadequate modes of governing the health sector reinforce the need for comprehensive policy reforms to realize the potential of public-health action. Fortunately, there are promising opportunities to build upon.

Opportunities for better public policies

Better information and evidence

Although there are strong indications that the potential gains from better public policies are enormous, the evidence base on their outcomes and on their cost-effectiveness is surprisingly weak. We know much about the relationship between certain behaviours – smoking, diet, exercise, etc. – and health outcomes, but much less about how to effect behavioural change in a systematic and sustainable way at population levels. Even in well-resourced contexts, the obstacles are many: the time-scale in achieving outcomes; the complexity of multifactorial disease causation and intervention effects; the lack of data; the methodological problems, including the difficulties in applying the well-accepted criteria used in the evaluation of clinical methods; and the different perspectives of the multiple stakeholders involved. Infectious disease surveillance is improving, but information on chronic diseases and their determinants or on health inequities is patchy and often lacks systematic focus. Even the elementary foundations for work on population health and the collection of statistics on births and deaths or diseases are deficient in many countries (Box 4.4).

Over the last 30 years, however, there has been a quantum leap in the production of evidence for clinical medicine through collaborative efforts such as the Cochrane Collaboration and the International Clinical Epidemiology Network. A similar advance is possible in the production of evidence on public policies, although such efforts are still too tentative compared to the enormous resources available for research in other areas of health, e.g. diagnostic and therapeutic medical technologies. There are, however, signs of progress in the increasing use of systematic reviews by policy-makers.

Two tracks offer potential for significantly strengthening the knowledge base:

- Speeding up the organization of systematic reviews of critical interventions and their economic evaluation. One way of doing this is by expanding the remit of existing health technology assessment agencies to include the assessment of public-health interventions and delivery modes, since this would make use of existing institutional capacities with ringfenced resources. The emerging collaborative networks, such as the Campbell Collaboration, can play a catalyzing role, exploiting
Box 4.4 The scandal of invisibility: where births and deaths are not counted

Civil registration is both a product of economic and social development, and a condition for modernization. There has been little improvement in coverage of vital registration (official recording of births and deaths) over recent decades (see Figure 4.3). Almost 40% (48 million) of 128 million global births each year go uncounted because of the lack of civil registration systems. The situation is even worse for deaths registration. Globally, two thirds (38 million) of 57 million annual deaths are not registered. WHO receives reliable cause-of-death statistics from only 31 of its 193 Member States.

International efforts to improve vital statistics infrastructure in developing countries have been too limited in size and scope. Neither, the global health community nor the countries have given the development of health statistics and civil registration systems the same priority as health interventions. Within the UN system, civil registration development has no identifiable home. There are no coordination mechanisms to tackle the problem and respond to requests for technical support for mobilizing the necessary financial and technical resources. Establishing the infrastructure of civil registration systems to ensure all births and deaths are counted requires collaboration between different partners in different sectors. It needs sustained advocacy, the nurturing of public trust, supportive legal frameworks, incentives, financial support, human resources and modernized data management systems.

Where it functions well, vital statistics provide basic information for priority setting. The lack of progress in the registration of births and deaths is a major concern for the design and implementation of PHC reforms.

Figure 4.3 Percentage of births and deaths recorded in countries with complete civil registration systems, by WHO region, 1975–2004

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<td>Africa</td>
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<tr>
<td>Americas</td>
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<tr>
<td>Eastern Mediterranean</td>
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<td>Europe</td>
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<tr>
<td>South-East Asia</td>
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<tr>
<td>Western Pacific</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Births</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaths</td>
<td></td>
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<td></td>
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</tbody>
</table>

*Source adapted from 54.

The scandal of invisibility: where births and deaths are not counted

Accelerating the documentation and assessment of whole-of-government approaches using techniques that build on the initial experience with “health impact assessment” or “health equity impact assessment” tools. Although these tools are still in development, there is growing demand from local to supra-national policy-makers for such analyses (Box 4.5). Evidence of their utility in influencing public policies is building up, and they constitute a strategic way of organizing more thoughtful cross-sector discussions. That in itself is an inroad into one of the more intractable aspects of the use of the available evidence base: the clear need for more systematic communication on the potential health gains to be derived from better public policies. Decision-makers, particularly in other sectors, are insufficiently aware of the health consequences of their policies, and of the potential benefits that could be derived from them. Communication beyond the realm of the specialist is as important as the production of evidence and requires more effective approaches to the dissemination of evidence among policy-makers. Framing population health evidence in terms of the health impact of policies, rather than in the classical modes of communication among health specialists, has the potential to change radically the type and quality of policy dialogue.

A changing institutional landscape

Along with lack of evidence, the area where new opportunities are appearing is in the institutional capacity for developing public policies that are aligned with PHC goals. Despite the reluctance, including from donors, to commit substantial funds to National Institutes of Public Health (NIPhs), policy-makers rely heavily on them or
on their functional equivalents. In many countries, NIPHs have been the primary repositories of independent technical expertise for public health, but also, more broadly, for public policies. Some have a prestigious track record: the Fiocruz in Brazil, the Instituto de Medicina Tropical “Pedro Kouri” in Cuba, Kansanterveyslaitos in Finland, the Centers for Disease Control and Prevention in the United States, or the National Institute of Hygiene and Epidemiology in Viet Nam. They testify to the importance that countries accord to being able to rely on such capacity.

Increasingly, however, this capacity is unable to cope with the multiple new demands for public policies to protect or promote health. This is leaving traditional national and global institutes of public health with an oversized, under-funded mandate, which poses problems of dispersion and difficulties in assembling the critical mass of diversified and specialized expertise (Figure 4.4). In the meantime, the institutional landscape is changing as the capacity for public policy support is being spread over a multitude of national and supra-national institutions. The number of loci of expertise, often specialized in some aspect of public policy, has increased considerably, spanning a broad range of institutional forms including: research centres, foundations, academic units, independent consortia and think tanks, projects, technical agencies and assorted initiatives. Malaysia’s Health Promotion Foundation Board, New Zealand’s Alcohol Advisory

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**Box 4.5 European Union impact assessment guidelines**

European Union guidelines suggest that the answers to the following questions can form the basis of an assessment of the impact of proposed public-health interventions.

**Public health and safety**

Does the proposed option:

- affect the health and safety of individuals or populations, including life expectancy, mortality and morbidity through impacts on the socioeconomic environment, e.g. working environment, income, education, occupation or nutrition?
- increase or decrease the likelihood of bioterrorism?
- increase or decrease the likelihood of health risks attributable to substances that are harmful to the natural environment?
- affect health because of changes in the amount of noise or air, water or soil quality in populated areas?
- affect health because of changes in energy use or waste disposal?
- affect lifestyle-related determinants of health such as the consumption of tobacco or alcohol, or physical activity?
- produce specific effects on particular risk groups (determined by age, sex, disability, social group, mobility, region, etc.)?

**Access to and effects on social protection, health and educational systems**

Does the proposed option:

- have an impact on services in terms of their quality and access to them?
- have an effect on the education and mobility of workers (health, education, etc.)?
- affect the access of individuals to public or private education or vocational and continuing training?
- affect the cross-border provision of services, referrals across borders and cooperation in border regions?
- affect the financing and organization of and access to social, health and education systems (including vocational training)?
- affect universities and academic freedom or self-governance?

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**Figure 4.4 Essential public-health functions that 30 national public-health institutions view as being part of their portfolio**

<table>
<thead>
<tr>
<th>Function</th>
<th>Proportion of institutions surveyed (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveillance, problem investigation, control of risks and threats to public health</td>
<td>100</td>
</tr>
<tr>
<td>Public health research</td>
<td>90</td>
</tr>
<tr>
<td>Evaluation and analysis of health status</td>
<td>80</td>
</tr>
<tr>
<td>Health promotion and prevention programmes</td>
<td>70</td>
</tr>
<tr>
<td>Planning and management</td>
<td>60</td>
</tr>
<tr>
<td>Reduction of the impact of disasters on health</td>
<td>50</td>
</tr>
<tr>
<td>Human resource development and training</td>
<td>40</td>
</tr>
<tr>
<td>Social participation and citizen empowerment</td>
<td>30</td>
</tr>
<tr>
<td>Regulation and enforcement</td>
<td>20</td>
</tr>
<tr>
<td>Quality assurance in personal and population-based health services</td>
<td>10</td>
</tr>
<tr>
<td>Evaluation and promotion of coverage and access to health services</td>
<td>0</td>
</tr>
</tbody>
</table>

Proportion of institutions surveyed (%)
Council and Estonia’s Health Promotion Commission show that funding channels have diversified and may include research grants and contracts, government subsidies, endowments, or hypothecated taxes on tobacco and alcohol sales. This results in a more complex and diffuse, but also much richer, network of expertise.

There are important scale efficiencies to be obtained from cross-border collaboration on a variety of public policy issues. For example, the International Association of National Public Health Institutes (IANPHI) helps countries to set up strategies for institutional capacity development. In this context, institution building will have to establish careful strategies for specialization and complementarity, paying attention to the challenge of leadership and coordination.

At the same time, this offers perspectives for transforming the production of the highly diverse and specialized workforce that better public policies require. Schools of public health, community medicine and community nursing have traditionally been the primary institutional reservoirs for generating that workforce. However, they produce too few professionals who are too often focused on disease control and classical epidemiology, and are usually ill-prepared for a career of flexibility, continuous learning and coordinated leadership.

The multi-centric institutional development provides opportunities for a fundamental rethink of curricula and of the institutional settings of pre-service education, with on-the-job training in close contact with the institutions where the expertise is located and developed. There are promising signs of renewal in this regard in the WHO South-East Asian Region (SEARO) that should be drawn upon to stimulate similar thinking and action elsewhere. The increasing cross-border exchange of experience and expertise, combined with a global interest in improving public policy-making capacity, is creating new opportunities – not just in order to prepare professionals in more adequate numbers but, above all, professionals with a broader outlook and who are better prepared to address complex public health challenges of the future.

**Equitable and efficient global health action**

In many countries, responsibilities for health and social services are being delegated to local levels. At the same time, financial, trade, industrial and agricultural policies are shifting to international level: health outcomes have to be obtained locally, while health determinants are being influenced at international level. Countries increasingly align their public policies with those of a globalized world. This presents both opportunities and risks.

In adjusting to globalization, fragmented policy competencies in national governance systems are finding convergence. Various ministries, including health, agriculture, finance, trade and foreign affairs are now exploring together how they can best inform pre-negotiation trade positions, provide input during negotiations, and weigh the costs and benefits of alternative policy options on health, the economy and the future of their people. This growing global health “interdependence” is accompanied by a mushrooming of activities expressed at the global level. The challenge is, therefore, to ensure that emerging networks of governance are adequately inclusive of all actors and sectors, responsive to local needs and demands, accountable, and oriented towards social justice. The recent emergence of a global food crisis provides further legitimacy to an input from the health sector into the evolving global response. Gradually, a space is opening for the consideration of health in the trade agreements negotiated through the World Trade Organization (WTO). Although implementation has proved problematic, the flexibilities agreed at Doha for provision in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) of compulsory licencing of pharmaceuticals are examples of emerging global policies to protect health.

There is a growing demand for global norms and standards as health threats are being shifted from areas where safety measures are being tightened to places where they barely exist. Assembling the required expertise and processes is complex and expensive. Increasingly, countries are relying on global mechanisms and collaboration. This trend started over 40 years ago with the creation of the Codex Alimentarius Commission in 1963.
by the Food and Agriculture Organization (FAO) and the WHO to coordinate international food standards and consumer protection. Another long-standing example is the International Programme on Chemical Safety, established in 1980 as a joint programme of the WHO, the International Labour Organization (ILO) and the United Nations Environment Programme (UNEP). In the European Union, the construction of health protection standards is shared between agencies and applied across Europe. Given the expense and complexity of drug safety monitoring, many countries adapt and use the standards of the United States Food and Drug Administration (FDA). WHO sets global standards for tolerable levels of many contaminants. In the meantime, countries must either undertake these processes themselves or ensure access to standards from other countries or international agencies, adapted to their own context.

The imperative for global public-health action, thus, places further demands on the capacity and strength of health leadership to respond to the need to protect the health of their communities. Local action needs to be accompanied by the coordination of different stakeholders and sectors within countries. It also needs to manage global health challenges through global collaboration and negotiation. As the next chapter shows, this is a key responsibility of the state.

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The preceding chapters have described how health systems can be transformed to deliver better health in ways that people value: equitably, people-centred, and with the knowledge that health authorities administer public-health functions to secure the well-being of all communities. These PHC reforms demand new forms of leadership for health. This chapter begins by clarifying why the public sector needs to have a strong role in leading and steering public health care reforms, and emphasizes the fact that this function should be exercised through collaborative models of policy dialogue with multiple stakeholders, because this is what people expect and because it is the most effective. It then considers strategies to improve the effectiveness of reform efforts and the management of the political processes that condition them.
Governments as brokers for PHC reform

Mediating the social contract for health

The ultimate responsibility for shaping national health systems lies with governments. Shaping does not suggest that governments should—or even could—reform the entire health sector on their own. Many different groups have a role to play: national politicians and local governments, the health professions, the scientific community, the private sector and civil society organizations, as well as the global health community. Nevertheless, the responsibility for health that is entrusted to government agencies is unique and is rooted in principled politics as well as in widely held expectations.

Politically, the legitimacy of governments and their popular support depends on their ability to protect their citizens and play a redistributive role. The governance of health is among the core public policy instruments for institutionalized protection and redistribution. In modern states, governments are expected to protect health, to guarantee access to health care and to safeguard people from the impoverishment that illness can bring. These responsibilities were progressively extended, incorporating the correction of market failures that characterize the health sector. Since the beginning of the 20th century, health protection and health care have progressively been incorporated as goods that are guaranteed by governments and are central to the social contract between the state and its citizens. The importance of health systems as a key element of the social contract in modernizing societies is most acutely evident during reconstruction after periods of war or disaster: rebuilding health services counts among the first tangible signs that society is returning to normal.

The legitimacy of state intervention is not only based on social and political considerations. There are also key economic actors—the medical equipment industry, the pharmaceutical industry and the professions—with an interest in governments taking responsibility for health to ensure a viable health market: a costly modern health economy cannot be sustained without risk sharing and pooling of resources. Indeed, those countries that spend the most on health are also those countries with the largest public financing of the health sector (Figure 5.1).

Even in the United States, its exceptionalism stems not from lower public expenditure—at 6.9% of GDP it is no lower than the high-income countries average of 6.7%—but from its singularly high additional private expenditure. The persistent under-performance of the United States health sector across domains of health outcomes, quality, access, efficiency and equity, explains opinion polls that show increasing consensus of the notion of government intervention to secure more equitable access to essential health care.

A more effective public sector stewardship of the health sector is, thus, justified on the grounds of greater efficiency and equity. This crucial stewardship role is often misinterpreted as a mandate for centralized planning and complete administrative control of the health sector. While some types of health challenges, e.g. public-health emergencies or disease eradication, may require authoritative command-and-control management, effective stewardship increasingly relies on “mediation” to address current and future complex health challenges. The interests of public authorities, the health sector and the public are closely intertwined. Over the years, this has made all the institutions of medical care, such as training, accreditation, payment, hospitals,
entitlements, etc., the object of intensive bargain-
ing on how broadly to define the welfare state and
the collective goods that go with it. This means
that public and quasi-public institutions have to
mediate the social contract between institutions
of medicine, health and society. In high-income
countries today, the health-care system and the
state appear indissolubly bound together. In low- and middle-income countries, the state has
often had a more visible role, but paradoxically,
one that was less effective in steering the health
sector, particularly when, during the 1980s and
1990s, some countries of them became severely
tested by conflicts and economic recession. This
resulted in their health systems being drawn in
directions quite different from the goals and val-
ues pursued by the PHC movement.

Disengagement and its consequences
In many socialist and post-socialist countries
undergoing economic restructuring, the state
has withdrawn abruptly from its previously pre-
dominant role in health. China’s deregulation of
the health sector in the 1980s, and the subse-
quently steep increases in reliance on out-of-pocket
spending, is a case in point and a warning to the
rest of the world. A spectacular deterioration of
health-care provision and social protection, par-
ticularly in rural areas, led to a marked slowdown
in the increase in life expectancy. This caused
China to re-examine its policies and reassert the
Government’s leadership role – a re-examination
that is far from over (Box 5.1)

A similar scenario of disengagement was
observed in many of the countries of central and eastern Europe and the Commonwealth of
Independent States (CEE-CIS). In the early 1990s,
public expenditure on health declined to levels
that made administering a basic system virtually
impossible. This contributed to a major decline
in life expectancy. Catastrophic health spending
became a major cause of poverty. More recently,
funding levels have stabilized or even increased,
but significant improvements in health outcomes
have not followed and socioeconomic inequalities
in health and health-care access are rising.
Evidence and trends related to these rises, as well
as increases in informal payment mechanisms
for health care, indicate that re-engagement is
still insufficient.

Elsewhere, but most spectacularly in low-
icome countries and fragile states, the absence
or withdrawal of the state from its responsibilities for health reflects broader conditions of
economic stagnation, political and social crisis
and poor governance. In such conditions, public
leadership has often become dysfunctional and
de-institutionalized, a weakness that is com-
pounded by a lack of financial leverage to steer
the health sector. Global development policies
have often added to the difficulties governments
face in assuming their responsibilities, for at
least two reasons.

- The global development agenda of the 1980s
and 1990s was dominated by concern for the
problems created by too much state involve-
ment. The structural adjustment and downsizing recipes of these decades still constrain
the reconstruction of leadership capacity
today. Public financing in the poorest countries
became unpredictable, making medium-term
commitments to the growth of the health sector
difficult or impossible. Health planning
based on needs became the exception rather
than the rule, since key fiscal decisions were
taken with little understanding of the potential
consequences for the health sector and health
ministries were unable to make an effective
case for prioritizing budget increases.

- For decades, the international community’s
health agenda – including that of WHO – has
been structured around diseases and inter-
ventions rather than around the broader chal-
lenges being faced by health systems. While
this agenda has certainly contributed to a
better appreciation of the burden of disease
affecting poor countries, it has also profoundly
influenced the structure of governmental and
quasi-governmental institutions in low- and
middle-income countries. The resulting frag-
mentation of the governance of the health sector
has diverted attention from important
issues, such as the organization of primary
care, the control of the commercialization of
the health sector and human resources for
health crises.
The untoward consequences of this trend are most marked in aid-dependent countries because it has shaped the way funds are channelled. The disproportionate investment in a limited number of disease programmes considered as global priorities in countries that are dependent on external support has diverted the limited energies of ministries of health away from their primary role as mediator in the comprehensive planning of primary care and the public’s health.

**Box 5.1 From withdrawal to re-engagement in China**

During the 1980s and 1990s, reduced Government engagement in the health sector exposed increasing numbers of Chinese households to catastrophic expenditures for health care. As a result, millions of families in both rural and urban areas found themselves unable to meet the costs and were effectively excluded from health care. In cities, the Government Insurance Scheme (GIS) and Labour Insurance Scheme (LIS) had previously covered more than half of the population with either full or partial health insurance. However, the structural weaknesses of these schemes reached critical levels under the impact of accelerating economic change in the 1990s. The percentage of China’s urban population not covered by any health insurance or health plan rose from 27.3% in 1993 to 44.1% in 1998. By the end of the century, out-of-pocket payments made up more than 60% of health expenditure. This crisis spurred efforts to invert the trend: pooling and pre-payment schemes were bolstered in 1998 with the introduction of Basic Medical Insurance (BMI) for urban employees.

Financed through compulsory contributions from workers and employers, the BMI aims to replace the old GIS and LIS systems. The BMI has aimed for breadth of coverage with a relatively modest depth of benefits, linked to flexibility that can enable the development of different types of packages according to local needs in the participating municipalities. Structurally, the BMI fund is divided into two parts: individual savings accounts and social pooling funds. Generally speaking, the financial contribution from an employee’s salary or wages goes to his or her individual savings account, while the employer’s contribution is split between the individual savings accounts and the social pooling fund, applying different percentages according to the age group of employees.

Financial resources under the new BMI are pooled at municipal or city level, instead of by individual enterprises, which significantly strengthens the capacity for risk sharing. Each municipal government has developed its own regulations on the use of the resources of individual savings accounts and social pooling funds (the two structural parts of the system). The individual savings accounts cover outpatient services, while the social pooling fund is meant to cover inpatient expenditures.

Significant difficulties with the BMI model remain to be ironed out, in particular as regards equity. For example, studies indicate that, in urban areas, better-off populations have been quicker to benefit from the provisions of the BMI than households with very low incomes, while informal sector workers remain on the margins of the scheme. Nonetheless, the BMI has made progress in expanding health insurance coverage and access to services among China’s urban population, and is instrumental in reversing the deleterious trends of the 1980s and 1990s and, at the same time, assigning a new, intermediary role to government institutions.

**Figure 5.2 Health expenditure in China: withdrawal of the State in the 1980s and 1990s and recent re-engagement**

As a result, multiple, fragmented funding streams and segmented service delivery are leading to duplication, inefficiencies and counterproductive competition for resources between different programmes. Consequently, the massive mobilization of global solidarity has not been able to offset a growing estrangement between country needs and global support, and between people's expectations for decent care and the priorities set by their health-sector managers. Moreover, the growth in aid-flow mechanisms and new implementing institutions has further heightened the degree of complexity faced by weak government bureaucracies in donor-dependent countries, increasing transaction costs for those countries that can least afford them. So much effort is required to respond to international partners’ short-term agendas that little energy is left to deal with the multiple domestic stakeholders – professions, civil society organizations, politicians, and others – where, in the long run, leadership matters most. As advocates have rightly argued in recent years, better inter-donor coordination is not going to solve this problem on its own: there is also an urgent need for reinvestment in governance capacity.

**Participation and negotiation**

The necessary reinvestment in governmental or quasi-governmental institutions cannot mean a return to command-and-control health governance. Health systems are too complex: the domains of the modern state and civil society are interconnected, with constantly shifting boundaries. Professions play a major role in how health is governed, while, as mentioned in Chapter 2, social movements and quasi-governmental autonomous institutions have become complex and influential political actors. Patients, professions, commercial interests and other groups are organizing themselves in order to improve their negotiating position and to protect their interests. Ministries of health are, also, far from homogenous: individuals and programmes compete for influence and resources, adding to the complexity of promoting change. Effective mediation in health must replace overly simplistic management models of the past and embrace new mechanisms for multi-stakeholder policy dialogue to work out the strategic orientations for PHC reforms.

At the core of policy dialogue is the participation of the key stakeholders. As countries modernize, their citizens attribute more value to social accountability and participation. Throughout the world, increasing prosperity, intellectual skills and social connectivity are associated with people’s rising aspiration to have more say in what happens at their workplaces and in their communities – hence the importance of people-centredness and community participation – and in important government decisions that affect their lives – hence the importance of involving civil society in the social debate on health policies.

Another reason that policy dialogue is so important is that PHC reforms require a broad policy dialogue to put the expectations of various stakeholders in perspective, to weigh up need, demand and future challenges, and to resolve the inevitable confrontations such reforms imply. Health authorities and ministries of health, which have a primary role, have to bring together the decision-making power of the political authorities, the rationality of the scientific community, the commitment of the professionals, and the values and resources of civil society. This is a process that requires time and effort (Box 5.2). It would be an illusion to expect PHC policy formation to be wholly consensual, as there are too many conflicting interests. However, experience shows that the legitimacy of policy choices depends less on total consensus than on procedural fairness and transparency.

Without a structured, participatory policy dialogue, policy choices are vulnerable to appropriation by interest groups, changes in political personnel or donor fickleness. Without a social consensus, it is also much more difficult to engage effectively with stakeholders whose interests diverge from the options taken by PHC reforms, including other sectors that compete for society's resources: for the “medico-industrial complex,” for whom PHC reform may imply a realignment of their industrial strategy and for vested interests, such as those of the tobacco or alcohol industries, where effective PHC reform constitutes a direct threat.
Effective policy dialogue

The institutional capacities to enable a productive policy dialogue are not a given. They are typically weak in countries where, by choice or by default, laissez-faire dominates the approach to policy formation in health. Even in countries with mature and well-resourced health systems there is scope, and need, for more systematic and institutionalized approaches: negotiation between health authorities and professional institutions is often well established, but is much less so with other stakeholders and usually limited to discussions on resource allocation for service delivery. Policy dialogue must be built. How to do that depends very much on context and background. Experience from countries that have been able to accelerate PHC reforms suggests three common elements of effective policy dialogue:

- the importance of making information systems instrumental to PHC reform;
- systematically harnessing innovations; and
- sharing lessons on what works.

Information systems to strengthen policy dialogue

Policy dialogue on PHC reforms needs to be informed, not just by better data, but also by information obtained through a departure from traditional views on the clients, the scope and the architecture of national health information systems (Figure 5.3).

Many national health information systems that are used to inform policy can be characterized as closed administrative structures through which there is a limited flow of data on resource use, services and health status. They are often only used to a limited extent by officials at national and global level when formulating policy reforms, while little use is made of critical information that could be extracted from other tools and sources (census data, household expenditure or opinion surveys, academic institutions, NGOs, health insurance agencies, etc.), many of which are located outside the public system or even outside the health sector.
Routine data from traditional health information systems fails to respond to the rising demand for health-related information from a multitude of constituencies. Citizens need easier access to their own health records, which should inform them about the progress being made in their treatment plans and allow them to participate in decisions related to their own health and that of their families and communities. Communities and civil society organizations need better information to protect their members’ health, reduce exclusion and promote equity. Health professionals need better information to improve the quality of their work, and to improve coordination and integration of services. Politicians need information on how well the health system is meeting society’s goals and on how public money is being used.

Information that can be used to steer change at the policy level is quite different from the data that most conventional health information systems currently produce. There is a need to monitor what the reforms are achieving across the range of social values and the associated outcomes that are central to PHC: equity, people-centredness, protection of the health of communities and participation. That means asking questions such as:
- is care comprehensive, integrated, continuous and effective?
- is access guaranteed and are people aware of what they are entitled to?
- are people protected against the economic consequences of ill-health?

Such questions go well beyond what can be answered by tracking health outcome indicators, resource use and service output, which is what conventional health information systems focus on. The paradigm shift required to make information systems instrumental to PHC reform is to refocus on what is holding up progress in reorienting the health system. Better identification of priority health problems and trends is important (and vital to anticipate future challenges) but, from a policy point of view, the crucial information is that which allows identification of the operational and systemic constraints. In low-income countries in particular, where planning has long been structured along epidemiological considerations, this can provide a new and dynamic basis for orienting systems development. The report by the Bangladesh Health Watch on the state of the country’s health workforce, for example, identified such systemic constraints and corresponding recommendations for the consideration of health authorities.

The multiplication of information needs and users implies that the way health information is generated, shared and used also has to evolve. This critically depends on accessibility and transparency, for example, by making all health-related information readily accessible via the Internet – as in Chile, where effective communication was considered both an outcome and a motor of their “Regime of Explicit Health Guarantees”. PHC reform calls for open and collaborative models to ensure that all the best sources of data are tapped and information flows quickly to those who can translate it into appropriate action.

Open and collaborative structures, such as the “Observatories” or “Equity Gauges” offer specific models of complementing routine information.
systems, by directly linking the production and dissemination of intelligence on health and social care to policy-making and to the sharing of best practices. They reflect the increasing value given to cross-agency work, health inequalities and evidence-based policy-making. They bring together various constituencies, such as academia, NGOs, professional associations, corporate providers, unions, user representatives, governmental institutions and others, around a shared agenda of monitoring trends, studies, information sharing, policy development and policy dialogue (Box 5.3).

Paradoxically, these open and flexible configurations provide continuity in settings where administrative and policy continuity may be affected by a rapid turnover of decision-makers.

In the Americas, there are observatories that specifically focus on human resource issues in 22 countries. In Brazil, for example, the observatory is a network of more than a dozen participating institutions (referred to as “workstations”): university institutes, research centres and a federal office, coordinated through a secretariat based at the Ministry of Health and the Brasilia office of PAHO. These networks played a key role in setting up Brazil’s current PHC initiatives. Such national and sub-national structures also exist in various European countries, including France, Italy and Portugal. Comparatively autonomous, such state/non-state multi-stakeholder networks can cover a wide range of issues and be sensitive to local agendas. In the United Kingdom, each regional observatory takes the lead on specific

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**Box 5.3 Equity Gauges: stakeholder collaboration to tackle health inequalities**

Equity Gauges are partnerships of multiple stakeholders that organize active monitoring and remedial action around inequity in health and health care. So far, they have been established in 12 countries on three continents. Some operate at a countrywide level, some monitor a subset of districts or provinces in a country, a few operate at a regional level and others focus specifically on equity within a city or municipality; nine have a national focus and three work at the municipal level (in Cape Town (South Africa), El Tambo (Ecuador) and Nairobi (Kenya). The Equity Gauges bring together stakeholders representing a diversity of local contexts, including parliamentarians and councillors, the media, ministries and departments of health, academic institutions, churches, traditional leaders, women’s associations, community-based and nongovernmental organizations, local authority organizations and civic groups. Such a diversity of stakeholders not only encourages wide social and political investment, but also supports capacity development within countries.

Equity Gauges develop an active approach to monitoring and dealing with inequity in health and health care. They move beyond a mere description or passive monitoring of equity indicators to a set of specific actions designed to effect real and sustained change in reducing unfair disparities in health and health care. This work entails an ongoing set of strategically planned and coordinated actions that involves a range of different actors who cut across a number of different disciplines and sectors.

The Equity Gauge strategy is explicitly based on three “pillars of action”. Each one is considered to be equally important and essential to a successful outcome and all three are developed in parallel:

- research and monitoring to measure and describe inequities;
- advocacy and public participation to promote the use of information to effect change, involving a broad range of stakeholders from civil society working together in a movement for equity;
- community involvement to involve poor and marginalized people as active participants in decision-making rather than passive recipients of measures designed for their benefit.

The Equity Gauge strategy consists, therefore, of a set of interconnected and overlapping actions – it is not, as the name might suggest, just a set of measurements. For example, the selection of equity indicators for measurement and monitoring should take account of the views of community groups and consider what would be useful from an advocacy perspective. In turn, the advocacy pillar relies on reliable indicators developed by the measurement pillar and may involve community members or public figures.

Equity Gauges choose indicators according to the particular needs of the country as well as of the stakeholders. Emphasis is placed, however, on generating trend data within all Gauges to enable understanding of progress over time. Indicators are measured across a variety of dimensions of health, including health status; health-care financing and resource allocation; access to health care; and quality of health care (such as maternal and child health, communicable diseases and trauma). All indicators are disaggregated according to the “PROGRESS” acronym that describes a broad range of socioeconomic factors often associated with inequities in health determinants: Place of residence, Religion, Occupation, Gender, Race/ethnicity, Education, Socioeconomic status and Social networks/capital.
issues, such as inequalities, primary care, violence and health, or the health of older people\textsuperscript{46}. All cover a wide range of issues of regional relevance (Table 5.1): they thus institutionalize the linkages between local developments and countrywide policy-making.

**Strengthening policy dialogue with innovations from the field**

These links between local reality and policy-making conditions the design and implementation of PHC reforms. The build up to the introduction of Thailand’s “30 Baht” universal coverage scheme provides an example of a deliberate attempt to infuse policy deliberations with learning from the field. Leaders of Thailand’s reform process organized a mutually reinforcing interplay between policy development at the central level and “field model development” in the country’s provinces. Health workers on the periphery and civil society organizations were given the space to develop and test innovative approaches to care delivery, to see how well they met both professional standards and community expectations (Figure 5.4). Field model development activities, which were supported by the Ministry of Health, were organized and managed at provincial level, and extensively discussed and negotiated with provincial contracts. Each province developed its own strategies to deal with its specific problems. The large amount of flexibility given to the provinces in deciding their own work programmes had the advantage of promoting ownership, fostering creativity and allowing original ideas to come forward. It also built local capacities. The downside to the high level of autonomy of the provinces was a tendency to multiply initiatives, making it difficult to evaluate the results to be fed into the policy work in a systematic way.

![Figure 5.4 Mutual reinforcement between innovation in the field and policy development in the health reform process](image)

| Table 5.1 Roles and functions of public-health observatories in England\textsuperscript{42} |
|-----------------------------------|---------------------------------|
| **Roles**                          | **Functions**                   |
| Monitoring health and disease trends and highlighting areas for action | Study on the inequalities existing in coronary heart disease, together with recommendations for action\textsuperscript{47} |
| Identifying gaps in health information | Study of current information sources and gaps on perinatal and infant health\textsuperscript{48} |
| Advising on methods for health and health inequality impact assessment | Overview of health impact assessment\textsuperscript{49} |
| Drawing together information from different sources in new ways to improve health | Health profile using housing and employment data alongside health data\textsuperscript{50} |
| Carrying out projects to highlight particular health issues | A study of the dental health of five-year-olds in the Region\textsuperscript{51} |
| Evaluating progress by local agencies in improving health and eliminating inequality | Baselines and trend data |
| Looking ahead to give early warning of future public health problems | Forum for partners to address likely future public health issues such as the ageing population and genetics |

\textsuperscript{42} Example: Northern and Yorkshire Public Health Observatory.

On balance, however, the difficulties due to the locally-driven approach were compensated for by the positive effects related to reform dynamics and capacity building. By 2001, nearly half of Thailand’s 76 provinces were experimenting with organizational innovation, most of it around issues of equitable access, local health-care systems and community health\textsuperscript{52}.

Thailand’s “30 Baht” universal coverage reform was a bold political initiative to improve health equity. Its transformation into a concrete reality was made possible through the accumulated experience from the field and through the alliances the fieldwork had built between health workers, civil society organizations and the public. When the scheme was launched in 2001, these provinces were ready to pilot and implement the
scheme. Furthermore, the organizational models they had developed informed the translation of political commitment to universal coverage into concrete measures and regulations.

This mutually reinforcing process of linking policy development with learning from the field is important for several reasons:

- it taps the wealth of latent knowledge and innovation within the health sector;
- bold experiments in the field give front-line workers, system leaders and the public an inspiring glimpse of what the future might look like in a health system shaped by PHC values. This overcomes one of the greatest obstacles to bold change in systems — people’s inability to imagine that things could actually be different and be an opportunity rather than a threat;
- the linking of policy development with front-line action fosters alliances and support from within the sector, without which far-reaching reform is not sustainable;
- such processes engage society both locally and at national level, generating the demand for change that is essential in building political commitment and maintaining the momentum for reform.

Building a critical mass of capacity for change

The stimulation of open, collaborative structures that supply reforms with strategic intelligence and harness innovation throughout the health system requires a critical mass of committed and experienced people and institutions. They must not only carry out technical and organizational tasks, but they must also be able to balance flexibility and coherence, adapt to new ways of working, and build credibility and legitimacy.

However, that critical mass of people and institutions is often not available. Institutions in low-income countries that have suffered from decades of neglect and disinvestment are of particular concern. They are often short on credibility and starved of resources, while key staff may have found more rewarding working environments with partner agencies. Poor governance complicates matters, and is compounded by international pressure for state minimalism and the disproportionate influence of the donor community. The conventional responses to leadership capacity shortfalls in such settings, which are characterized by a heavy reliance on external technical assistance, toolkits and training, have been disappointing (Box 5.4). They need to be replaced by more systematic and sustainable approaches in order to institutionalize competencies that learn from and share experience.

Documented evidence of how individual and institutional policy dialogue and leadership capacities build up over time is hard to find, but a set of extensive interviews of health sector leaders in six countries shows that personal career trajectories are shaped by a combination of three decisive experiences.

- At some point in their careers, all had been part of a major sectoral programme or project, particularly in the area of basic health services. Many of them refer to this as a formative experience: it is where they learned about PHC, but also where they forged a commitment and started building critical alliances and partnerships.
- Many became involved in national planning exercises, which strengthened their capacity to generate and use information and, again, their capacity to build alliances and partnerships.
- Few had participated personally in major studies or surveys, but those who had, found it an opportunity to hone their skills in generating and analyzing information.

All indicated the importance of cooptation and coaching by their elders: “You have to start out as a public health doctor and be noticed in one of the networks that influence decision making in MOH. After that your personal qualities and learning by doing determine whether you’ll get to be in a position of leadership.”

These personal histories of individual capacity strengthening are corroborated by more in-depth analysis of the factors that contributed to the institutional capacities for steering the health sector in these same countries. Table 5.2 shows that opportunities to learn from large-scale health-systems development programmes have contributed most, confirming the importance of hands-on engagement with the problems of the health sector in a collaborative environment.
The development community has always tended to respond to the consequences of institutional disinvestment in low- and middle-income countries through its traditional arsenal of technical assistance and expert support, toolkits and training (Figure 5.5). From the 1980s onwards, however, it became clear that such “technical assistance” was no longer relevant and the response re-invented itself as “project management units” concentrating on planning, financial management and monitoring.

The stronger health systems were able to benefit from the resources and innovation that came with projects but, in others, the picture was much more mixed. As a recurrent irritant to national authorities, accountability to funding agencies often proved stronger than commitment to national development: demonstrating project results took precedence over capacity building and long-term development, giving disproportionate weight to project managers at the expense of policy coherence and country leadership. In more recent years, the wish to reinforce country ownership – and changes in the way donors purchase technical assistance services – paved the way for a shift from project management to the supply of short-term expertise through external consultants.

In the 1980s and early 1990s, the expertise was essentially provided by academic institutions and the in-house experts of bilateral cooperation and United Nations agencies. The increased volume of funding for technical support contributed to shifting the expertise market to freelance consultants and consultancy firms, so that expertise has become increasingly provided on a one-time basis, by technical experts whose understanding of the systemic and local political context is necessarily limited.

In 2006, technical cooperation constituted 41% of total overseas development aid for health. Adjusted for inflation, its volume tripled between 1999 and 2006, particularly through expansion of technical cooperation on HIV/AIDS. Adapting to the complexities of the aid architecture, experts and consultants now also increasingly act as intermediaries between countries and the donor community: harmonization has become a growth business, lack of country capacity fuelling further disempowerment.

The second mainstream response to the capacity problem has been the multiplication of planning, management and programme toolkits. These toolkits promise to solve technical problems encountered by countries while aiming for self-reliance. For all their potential, rigour and evidence base, the usefulness of toolkits in the field has often not lived up to expectations for four main reasons.

- They often underestimate the complexity of the problems they are supposed to deal with.
- They often rely on international expertise for their implementation, thereby defeating one of their main purposes, which is to equip countries with the ways and means to deal with their problems themselves.
- Some have not delivered the promised technical results or led to unexpected unintended side-effects.
- The introduction of toolkits is largely supply driven and linked to institutional interests, which makes it difficult for countries to choose among the multitude of competing tools that are proposed.

The capacity-building prescription that completes the spectrum is training. Sometimes, this is part of a coherent strategy: Morocco’s Ministry of Health, for example, has applied a saturation training approach similar to that of Indonesia’s Ministry of Finance, sending out large numbers of young professionals for training in order to build up a recruitment base of qualified staff and, eventually, a critical mass of leaders. Such deliberate approaches, however, are rare. Much more common are short “hotel” training courses that mix technical objectives and exchange with implicit aims to top-up salaries and buy political goodwill. The prevailing scepticism about the usefulness of such programmes (systematic evaluation is uncommon) contrasts sharply with the resources they mobilize, at a considerable opportunity cost.

In the meantime, new markets in education, training and virtual learning are developing, while actors in low- and middle-income countries can access Internet sites on most health systems issues and establish electronic communities of practice. With contemporary information technology and globalization, traditional recipes for capacity development in poor countries are quickly becoming obsolete.
Especially noteworthy is the fact that the introduction of tools was rarely identified as a critical input, and respondents did not highlight inputs from experts and training.

The implication is that the key investment for capacity building for PHC reforms should be to create opportunities for learning by linking individuals and institutions to ongoing reform processes. A further consideration is the importance of doing so in an environment where exchange, within and between countries, is facilitated. Unlike the conventional approaches to capacity building, exchange and exposure to the experience of others enhances self-reliance. This is not just a recipe for under-resourced and poorly performing countries. Portugal, for example, has organized a broad societal debate on its 2004–2010 National Health Plan involving a pyramid of participation platforms from local and regional to national level, and 108 substantial contributions to the plan from sources ranging from civil society and professional organizations to local governments and academia. At three critical moments in the process, international panels of experts were also invited from other countries to act as sounding boards for their policy debate: a collaboration that was a learning exercise for all parties.

Managing the political process: from launching reform to implementing it

PHC reforms change the balance of power within the health sector and the relationship between health and society. Success depends not only on a credible technical vision, but also on the ability to obtain the high-level political endorsement and the wider commitment that is necessary to mobilize governmental, financial and other institutional machineries.

As a technical sector, health rarely has prominence in the hierarchy of the political arena. Ministries of health have often had enough to deal with simply trying to resolve the technical challenges internal to the sector. They are traditionally ill at ease, short of leverage and ill equipped to make their case in the wider political arena, particularly in low- and low-middle-income countries.

The general lack of political influence limits the ability of health authorities, and of other stakeholders in the PHC movement, to advance the PHC agenda, especially when it challenges the interests of other constituencies. It explains the frequently absent or overly cautious reactions against the health effects of working conditions and environmental damage, or the slow implementation of regulations that may interfere with the commercial interests of the food and tobacco industry. Similarly, ambitious reform efforts are often diluted or watered down under the influence of the donor community, the pharmaceutical and the health technology industries, or the professional lobbies.

Lack of political influence also has consequences within governmental spheres. Ministries of health are in a particularly weak position in low- and low-middle-income countries, as is evidenced by the fact that they can claim only 4.5% and 1.7%, respectively, of total government expenditure (against 10% and 17.7%, respectively, in upper-middle and high-income countries).

The lack of prominence of health priorities in wider development strategies, such as the Poverty Reduction Strategy Papers (PRSPs), is another illustration of that weakness. Equally, ministries of health are often absent in discussions about caps on social (and health) spending, which

### Table 5.2 Significant factors in improving institutional capacity for health-sector governance in six countries

<table>
<thead>
<tr>
<th>Factors</th>
<th>No. of countries where factor was an important contributor</th>
<th>Average score for strength of contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector programmes/large-scale projects</td>
<td>4</td>
<td>7.25</td>
</tr>
<tr>
<td>Establishment of institutions</td>
<td>3</td>
<td>6.7</td>
</tr>
<tr>
<td>National policy debate events</td>
<td>3</td>
<td>5.6</td>
</tr>
<tr>
<td>Research, studies and situation analysis</td>
<td>4</td>
<td>5.1</td>
</tr>
<tr>
<td>New planning and management tools</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

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*a* Burkina Faso, the Democratic Republic of the Congo, Haiti, Mali, Morocco and Tunisia.

*b* Identified through document analysis and interviews with 136 key informants.
are dominated by debates on macroeconomic stability, inflation targets or sustainable debt. It is telling that, in highly indebted countries, the health sector’s efforts to obtain a share of the debt relief funds have been generally slow, less than forceful and unconvincing compared to education, foregoing possibilities for rapid expansion of their resource base.69

Despite these challenges, there is a growing indication that the political will for ambitious reforms based on PHC is taking place. India’s health missions – “rural” and subsequently “urban” – are accompanied by a doubling of public expenditure on health. China is preparing an extremely ambitious rural PHC reform that also includes a major commitment of public resources. The size and comprehensiveness of PHC-oriented reforms in Brazil, Chile, Ethiopia, the Islamic Republic of Iran, New Zealand, Thailand and many other countries, reflect very clearly that it is not unrealistic to mobilize political will. Even in extremely unfavourable circumstances, it has proven possible to gain credibility and political clout through pragmatic engagement with political and economic forces (Box 5.5).

Experience across these countries shows that political endorsement of PHC reforms critically depends on a reform programme that is formulated in terms that show its potential political dividends. To do that it has to:

- respond explicitly to rising demand as well as to the health challenges and health system constraints the country faces, showing that it is not merely a technical programme, but one rooted in concerns relevant to society;
- specify the expected health, social and political returns, as well as the relevant costs, in order to demonstrate the expected political mileage as well as its affordability;
- be visibly based on the key constituencies’ consensus to tackle the obstacles to PHC, providing reassurance of the reforms’ political feasibility.

Creating the political alignment and commitment to reform, however, is only a first step. Insufficient preparation of its implementation is often the weak point. Of particular importance is an understanding of resistance to change, particularly from health workers.70,71,72,73 While the intuition of leadership has its merits, it is also possible to organize more systematic exercises to anticipate and respond to the potential reactions of stakeholders and the public: political mapping exercises, as in Lebanon;34 marketing studies and opinion polls, as in the United States;24 public hearings, as in Canada; or sector-wide meetings of stakeholders, as in the *Etats Généraux de la Santé* in French-speaking Africa. Delivering on PHC reforms requires a sustained management capacity across levels of the system, embedded in institutions that are fit for the purpose. In Chile, for example, administrative structures and competencies across the whole of the Ministry of Health are being redefined in line with the PHC reforms. Such structural changes are not sufficient. They need to be instigated in conjunction with changes in the organizational culture, from one of issuing decrees for change to a more inclusive collaboration with a variety of stakeholders across the levels of the health system. That in turn requires the institutionalization of policy-dialogue mechanisms drawing practice-based knowledge up from the ground level to inform overall systems governance, while reinforcing social linkages and collaborative action among constituencies at community level.75 This management capacity should not be assumed, it requires active investment.

Even with effective political dialogue to gain consensus on specific PHC reforms and the requisite management for implementation across levels of the system, many such reforms do not have their intended impact. The best-planned and executed policy reforms often run into unanticipated challenges or rapidly changing contexts. Broad experience in dealing with complex systems behaviour suggests that significant shortfalls or shifts away from articulated goals are to be expected. An important component to build into the reform processes is mechanisms that can pick up significant unintended consequences or deviations from expected performance benchmarks, which allow for course corrections during implementation.

Widespread evidence on inequities in health and health care in virtually all countries is a humbling reminder of the difficulties confronting...
Recent developments in the Democratic Republic of the Congo show how renewed leadership can emerge even under extremely challenging conditions. The beginnings of the reconstruction of the country’s health system, devastated by economic collapse and state failure culminating in a brutal war, is above all, a story of skilful political management.

The Democratic Republic of the Congo had seen a number of successful experiences in PHC development at the district level during the 1970s and early 1980s. The economic and political turmoil from the mid-1980s onwards saw central government authority in health disintegrate, with an extreme pauperization of the health system and the workers within it. Health workers developed a multiplicity of survival strategies, charging patients and capitalizing on the many aid-funded projects, with little regard for the consequences for the health system. Donors and international partners lost confidence in the district model of integrated service delivery in the country and instead chose to back stand-alone disease control and humanitarian aid programmes. While, between 1999 and 2002, the Ministry of Health commanded less than 0.5% of total government expenditure, its central administration and its Department of Planning and Studies – 15 staff in total – faced the overwhelming task of providing guidance to some 25 bilateral and multilateral agencies, more than 60 international and 200 national NGOs, 53 disease control programmes (with 13 government donor coordination committees) and 13 provincial ministries of health – not forgetting health-care structures organized by private companies and universities.

As the intensity of civil strife abated, a number of key Ministry of Health staff took it upon themselves to revitalize and update the district model of primary health care. Aware of the marginal position of the Ministry in the health sector, they co-opted the “internal diaspora” (former civil servants now working for the many international development agencies present in the country) in an open structure around the Ministry. This steering group drafted a national health systems strengthening strategy. It included (i) a progressive roll-out of integrated services, district by district, coordinated through regional plans and backed by a fundamental shift in funding from programme-specific flows to system funding; (ii) a set of protective “damage-control” measures to halt institutional inflation and prevent further distortion of the system; and (iii) an explicit plan to tackle the problem of donor fragmentation, which had reached critical proportions. In designing the strategy, the steering group made deliberate efforts to set up networks within the health sector itself and alliances with other government actors and social constituencies.

The formal endorsement of the national plan by donors and civil society sent a strong political signal of the success of this new mode of working. The national health systems strengthening strategy became the health component of the national poverty reduction strategy. Donors and international partners aligned existing projects, albeit to a variable degree, while others reshaped new initiatives to fit the national strategy.

Perhaps the most powerful testimony to the effective management of this process is the change in the composition of donor funding for health (Figure 5.6). The proportion of funds dedicated to general systems strengthening under provincial and district plans has increased appreciably in relation to the level of funding earmarked for disease control and humanitarian relief programmes. The advances remain fragile, in a context where much of the health sector – including its governance – needs to be reconstructed.

Nevertheless, the national strategy has strong roots in fieldwork and, in a remarkable turnaround against high odds, the Ministry of Health has gained credibility with other stakeholders and has improved its position in renegotiating the finances of the health sector.
PHC reforms. This chapter has emphasized that leadership for greater equity in health must be an effort undertaken by the whole of society and engage all relevant stakeholders. Mediating multi-stakeholder dialogues around ambitious reforms be they for universal coverage or primary care places a high premium on effective government. This requires re-orienting information systems the better to inform and evaluate reforms, building field-based innovations into the design and redesign of reforms, and drawing on experienced and committed individuals to manage the direction and implementation of reforms. While not a recipe, these elements of leadership and effective government constitute in and of themselves a major focus of reform for PHC. Without reforms in leadership and effective government, other PHC reforms are very unlikely to succeed. While necessary, therefore, they are not sufficient conditions for PHC reforms to succeed. The next chapter describes how the four sets of PHC reforms must be adapted to vastly different national contexts while mobilizing a common set of drivers to advance equity in health.

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The starkly different social, economic and health realities faced by countries must inform the way forward for primary health care. This chapter discusses the implications for the way universal coverage, primary care, public policy and leadership reforms are operationalized. It shows how expanding health systems offer opportunities for PHC reform in virtually every country. Despite the need for contextual specificity, there are cross-cutting elements in the reforms, common to all countries, which provide a basis for globally shared learning and understanding about how PHC reforms can be advanced more systematically everywhere.
Adapting reforms to country context

Although insufficiently acknowledged, the PHC movement has been a critical success in that it has contributed to the recognition of the social value of health systems, which has now taken hold in most countries in the world. This change of mindset has created a radically different health-policy landscape.

Present-day health systems are a patchwork of components, many of which may be far removed from the goals set out 30 years ago. These same health systems are converging. Driven by the demographic, financial and social pressures of modernization, they increasingly share the aims of improved health equity, people-centred care, and a better protection of the health of their populations.

However, that does not mean that health systems across the world will change overnight. Reorienting a health system is a long-term process, if only because of the long time lag to restructure the workforce\(^1\) and because of the enormous inertia stemming from misaligned financial incentives and inadequate payment systems\(^2\). Given the countervailing forces and vested interests that drive health systems away from PHC values, reform requires a clear vision for the future. Many countries have understood this and are developing their strategic vision of public policies for health with a perspective of 10 to 20 years.

These visions are often couched in technical terms and are highly vulnerable to electoral cycles. Nevertheless, they are also increasingly driven by what people expect their health authorities to do: secure their health and improve access to care, protect them against catastrophic expenditure and financial exploitation, and guarantee an equitable distribution of resources\(^3,4\). As shown throughout this Report, the pressure that stems from these value-based expectations, if used resolutely, can ensure that the vision is not deflected and safeguard it from capture by short-term vested interests or changes in political leadership.

The protection this offers is greatly reinforced by early implementation. The possibilities to start effecting change as of now exist in virtually all countries: the growth of the health sector provides financial leverage to do so, and globalization is offering some unprecedented opportunities to make use of that leverage.

This does not in any way diminish the need to recognize the widely divergent contexts in which countries find themselves today: the nature of the health challenges they face and their wider socio-economic reality; and the degree of adaptation to challenges, the level of development and speed at which their health systems expand.

Opportunity for change is largely related to the flow of new resources into the health sector. Across the world, expenditure on health is growing: between 1995 and 2005, it almost doubled from I$ 2.6 to I$ 5.1 trillion. The rate of growth is accelerating: between 2000 and 2005, the total amount spent on health in the world increased by I$ 330 billion on average each year, against an average of I$ 197 billion in each of the five previous years. Health expenditure is growing faster than GDP and faster than population growth. The net result is that, with some exceptions, health spending per capita grows at a rate of more than 5% per year throughout the world.

This common trend in the growth in health expenditure masks a greater than 300-fold variation across countries in per capita expenditure, which ranges from less than I$ 20 per capita to well over I$ 6 000. These disparities stratify countries into three categories: high-expenditure health economies, rapid-growth health economies, and low-expenditure, low-growth health economies.

The high-expenditure health economies, not surprisingly, are those of the nearly 1 billion people living in high-income countries. In 2005, these countries spent on average I$ 3752 per capita on health, I$ 1563 per capita more than in 1995: a growth rate of 5.5% per year.

At the other extreme is a group of low-expenditure, low-growth health economies: low-income countries in Africa and South- and South-East Asia, as well as fragile states. They total 2.6 billion inhabitants who spent a mere I$ 103 per capita on health in 2005, against I$ 58 in 1995. In relative terms, these countries have seen their health expenditure per capita grow at roughly the
same rate as high-expenditure countries: 5.8% each year since 1995, but, in absolute terms, the growth has been disappointingly low.

In between those two groups are the other low- and middle-income countries, those with rapid-growth health economies. The 2.9 billion inhabitants in these countries spent an average of IS 413 per capita in 2005, more that double the IS 189 per capita that they spent in 1995. Health expenditure in these countries has been growing at a rate of 8.1% per year.

These groups differ not only in the rate and size of their growth in health expenditure. A breakdown according to the source of growth reveals strikingly different patterns (Figure 6.1). In the low-expenditure, low-growth health economies, out-of-pocket payments account for the largest share of the growth, while in rapid-growth and high-expenditure health economies, increased government expenditure and pre-payment mechanisms dominate. Where growth in health expenditure is through pre-payment mechanisms, there is greater opportunity to support PHC reforms: collectively pooled monies are more readily re-allocated towards interventions that provide a larger health return on investment than out-of-pocket payments. Conversely, countries where growth is primarily through out-of-pocket expenditures have less leverage to support PHC reforms. Alarmingly, it is in countries where expenditure is the lowest and the burden of disease highest that there is a real lack of opportunities for harnessing the growth of their health sector for PHC reforms.

The following sections outline broad categories of contexts that can shape responses for PHC reforms.

**High-expenditure health economies**

This group of countries funds almost 90% of its growth in health expenditure – an extra IS 200 per capita per year in recent years – through increased government and private pre-payment funds. Expanding or changing the offer of services in these countries is less constrained by finances than by the relative lack of human resources to meet rising and changing demand. Their health systems are built around a strong and prestigious tertiary care sector that is important to the heavy-weights of the pharmaceutical and medical supply industries. Out-of-pocket payments, though still significant at 15% of total expenditure, have been dwarfed by more progressive collective means of financing. The third-party payment institutions have, thus, become central actors while the long-standing autonomy of the health professionals is waning. Efforts to control costs, improve quality and access to disadvantaged groups have given rise to a widening public debate on which users and special interest groups have increasing influence. Nevertheless, the state carries more weight in the health sector of these countries than ever before, with increasingly sophisticated regulatory tools and institutions.

Despite worries over their long-term sustainability, the solidarity mechanisms that finance these health systems enjoy considerable social consensus. The secular trend towards extension of coverage to all citizens, and, often reluctantly, to non-citizen residents as well, continues. In the state of Massachusetts, the United States, for example, the 2006 health insurance bill aims at 99% coverage by 2010. At the same time, it is becoming increasingly clear that universal
coverage schemes need to be complemented by efforts: (i) to identify those who are excluded and set up specifically tailored programmes to include them; and (ii) to tackle the social determinants of health inequalities through policy initiatives that cut across a large number of sectors (Box 6.1), so as to translate the political commitment to health equity into concrete advances.

In many of these countries, the shift in point of gravity from tertiary and specialized care to primary care is well under way. Better information and technological developments are creating new opportunities – and a market – for moving much of the traditionally hospital-based care into local services staffed by primary-care teams or even into the hands of patients themselves. This is fuelling a change in perception of how health services should operate. It provides support for primary care, including self-care and home care. Movement in this direction, however, is held up by inertial forces stemming from the threat of downsizing and dismantling massive tertiary-care facilities and from demand induced by the illusion that the extension of life through technology is unlimited.

Technological innovation is indeed a driver of improvement and current trends show that it is expanding the range of services offered by primary-care teams. Technological innovation can, however, also be a driver of exclusion and inefficiency. The marked inter-country differences in the diffusion of medical technology are a reflection, not of rational evaluation, but of the incentives to providers to adopt these technologies, and the capacity to control that adoption.

There are two reasons why the environment in which this is taking place is changing.

- Public contestation of the management of technology has continued to increase for reasons of trust, price, exclusion or unmet need.

- Regulation increasingly depends on supranational institutions. The European Union’s regulatory system, for example, plays an increasing role in the harmonization of the technical requirements for registering new medicines or of product licencing, offering possibilities, among others, for more effective support to legal provisions encouraging generic substitution for pharmaceuticals in the private sector.

Such mechanisms offer opportunities to increase safety and access, and thus create an environment in which national primary care reforms are encouraged.

This comes at a time when the supply of professionals willing and able to engage in primary care is under stress. In Europe, for example, the population of general practitioners is ageing rapidly, and new recruits are more likely than before to opt for part-time or low-intensity careers.

There is pressure to give a more pivotal role to

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Box 6.1 Norway’s national strategy to reduce social inequalities in health

Norway’s strategy to reduce health inequalities illustrates that there is no single solution to this complex problem. Norway has identified a large number of determinants that influence the health of individuals: income, social support, education, employment, early childhood development, healthy environments and access to health services. These complex and interrelated determinants of health are not equally distributed in society, and it is, therefore, not surprising that this leads to inequities in health as well.

The Norwegian strategy attempts to address the root causes of poor health and health inequity by influencing the underlying determinants of health, and making the distribution of these determinants more equitable from the outset. The Norwegian strategy focuses on:

- reducing social inequities;
- reducing inequities in health behaviours and access to health services;
- targeted initiatives to improve social inclusion;
- and cross-sectoral tools to promote a whole-of-government approach to health.

This brings together a number of interventions that are effective in tackling inequities, and that can be applied both within health systems, as well as through cooperation with other sectors. For instance, health systems are able to establish programmes for early childhood development as well as policies that reduce financial, geographical and social barriers to health services for those who need care the most. Working with other sectors, such as labour and finance, can create job opportunities and taxation systems that encourage more equitable distribution and redistribution of wealth, which can have a large impact on population health. In addition to universal approaches, social inclusion interventions targeted at providing better living conditions for the most disadvantaged are also critical in reducing the gaps between the most well-off and the least well-off members of society.
family physicians in primary care\(^9\). In the long run, however, a more pluralistic approach will be required with teams that include a variety of professionals with the instruments to provide coordination and continuity of care. That will require a different, more varied and more flexible cadre of health workers. The sustainability of primary-care reforms in the category of high-spending countries is questionable without: (i) a change in paradigm of the training of health personnel; and (ii) the necessary career, social and financial incentives to move health professionals to what in the past have been less prestigious and rewarding career options.

Spurred by the growing awareness of global health threats and of the stratification of health outcomes along social fault lines, there is a major renaissance in public health. The connections between health and other sectors are better understood and are bringing health to the attention of all sectors. Research and information systems, demand for public health training and new discourses on public health are occupying the centre stage of public concerns. This situation needs to be translated into multi-pronged cross-sector strategies to address the social determinants of health and their influence on priority health challenges (Box 6.1).

Over the last decades, most countries in this category are leading reforms through a steer-and-negotiate rather than a command-and-control approach. This reflects the growing public visibility of the health-policy agenda and the need to find a balance between the different and often irreconcilable demands of diverse constituencies. As a result, reform efforts are usually multi-levelled, with multiple actors. They progress incrementally: a protracted messy process of muddling through and hard bargaining. In England and Wales, for example, a major primary-care reform included an extensive public consultation through questionnaires addressed to more than 42 000 people, while over 1 000 individuals were invited to voice their interests and concerns in public hearings. This involvement facilitated consensus on a number of contentious parts of the reform, including shifts of resources to primary care and to underserved areas, while responsibilities were redistributed to improve cooperation and coordination\(^10\). Time and effort for systematic but principled negotiation is the price to pay for obtaining the social consensus that can overcome entrenched resistance to reform.

**Rapid-growth health economies**

In rapid-growth health economies, the challenge of engaging PHC reforms presents itself quite differently. The growing demand that comes with increased purchasing power is fuelling an expansion of services at unprecedented speed. Assuming current growth rates continue through to 2015, per capita health expenditure will grow by 60% in the fast-growing health economies of the Americas compared to 2005 levels. In the same time period, that expenditure will double in Europe and the Middle-East and triple in East Asia (Figure 6.2).

![Figure 6.2 Projected per capita health expenditure in 2015, rapid-growth health economies (weighted averages)](image)

While the rate of growth in expenditure represents an opportunity to engage in PHC reforms, it also fuels patterns of health-sector development that run counter to the vision and values
of PHC. Beginnings count: policy choices that are made for political or technical expediency, such as to refrain from regulating commercial health care, may make it more difficult to redirect health systems towards PHC values at a later stage, as powerful vested interests emerge and patterns of supply-induced demand become entrenched. Biases towards highly sophisticated and specialized infrastructures that cater to the expectations of a wealthy minority are being further fuelled by a new growth market in medical tourism whereby patients from high-expenditure health economies with high-fixed costs are out-sourced to these comparatively low-cost environments. This drains the supply of professionals for primary care, encouraging unprecedented rates of specialization within the workforce. In contrast with these developments, ministries of health in many of these countries are still organized around specific disease control efforts, and are ill-equipped to use the leverage of expanding resources to regulate health-care delivery. The result is all too often a two-tiered system, with highly sophisticated and specialized health infrastructure that caters to expectations of a wealthy minority, in the presence of huge gaps in service availability for a large part of the population.

Reforms that emphasize universal access to people-centred primary care can help to correct such distortions. These reforms can take advantage of technological innovations that facilitate rapid, simple, reliable and low-cost access to services that were previously inaccessible because they were too expensive or required complex supportive infrastructure. Such innovations include rapid diagnostic tests for HIV and gastric ulcers, better drugs that facilitate the shift from institution-based to primary care-based mental health, and advances in surgery that either eliminate or dramatically reduce the need for hospitalization. Combined with the multiplication of evidence-based guidelines, such innovations have considerably enlarged the problem solving capacity of primary-care teams, broadening the role of non-physician clinicians and the potential of self-care. Rapid expansion of people-centred care is thus possible in a context where the technological gap between close-to-client ambulatory care and tertiary institutions is less striking than it was 30 years ago. Chile, for example, has doubled the uptake of primary-care services in a period of five years, along with a massive investment in personnel and equipment ranging from emergency dental care and laboratories to home-based management of chronic pain. The impact of this transformation can be amplified by targeting and empowering the large numbers of poor and excluded in these countries and by reforming public policies accordingly.

In the rapid-growth health economies of the Americas and the European region less that one third of the expected growth on current trends is through increased out-of-pocket expenditure on health. Two thirds are through increased government expenditure, in combination, in the Americas, with expanded private pre-paid expenditure (Figure 6.2). The latter also plays a growing role in the Far East, where, as in the Middle East, around 40% of the growth, on current trends, will be in out-of-pocket expenditure. Leverage of PHC reforms will depend in part on the possibility to regulate and influence private pre-paid expenditure, and, particularly in Asia, to curb the reliance on out-of-pocket expenditure.

In most of these countries, the level of expenditure compared to GDP or to total government expenditure remains low, offering financial room to further accelerate PHC reforms and underpin them through parallel, and equally important, moves towards universal coverage and reduced reliance on out-of-pocket payments. In many of these countries, public resources are allocated on a capitation basis as are, at least, part of pooled private pre-payment funds. This provides opportunities to include criteria, such as relative deprivation or unmet health needs in the capitation formulas. This effectively transforms resource allocation into an instrument for promoting health equity and for introducing incentives favouring conversion towards primary care and healthier public policies.

Some of the largest countries in the world – Brazil, for example – are now seizing these kinds of opportunities on a massive scale, expanding their primary-care networks while diminishing their reliance on out-of-pocket payments. Such reforms, however, rarely come about without pressure from the user’s side. Chile’s health policy
has defined a detailed benefit package, well publicized among the population as an enforceable right. People are being informed about the kind of services, including access to specialized care, which they can claim from their primary-care teams. In combination with sustained investment, such unambiguous entitlements create a powerful dynamic for the development of primary care. Managed well, they have the potential to accelerate convergence while avoiding at least part of the distortions and inefficiencies that have plagued high-income countries in earlier years.

**Low-expenditure, low-growth health economies**

With 2.6 billion people and less than 5% of the world’s health expenditure, countries in this group suffer from an absolute under-funding of their health sector, along with a disproportionately high disease burden. The persistence of high levels of maternal mortality in these countries – they claim close to 90% of all maternal deaths – is perhaps the clearest indication of the consequences of the under-funding of health on the performance of their health systems.

Worryingly, growth in health expenditure in these countries is low and highly vulnerable to their political and economic contexts. In fragile states, particularly in those located in Africa, health expenditure is not only low but barely growing at all, and 28% of this little amount of growth in recent years is accounted for by external aid. Health expenditure in the other countries of this group is growing at a stronger average rate of 6% to 7% per year. On current trends, by 2015, per capita health expenditure will have more than doubled in India compared to 2005, and increased by half elsewhere, except in fragile states (Figure 6.3). In many countries, this represents significant leverage to engage PHC reforms, particularly where the growth is through increased government expenditure or, as in Southern Africa, through other forms of pre-payment. In India, however, more than 80% of the growth will, on current trends, be in out-of-pocket expenditure, offering much less leverage.

Countries in these regions accumulate a set of problems that in all their diversity share many characteristics. Whole population groups are excluded from access to quality care: because no services are available; because they are too expensive, or under-funded, under-staffed and under-equipped; or because they are fragmented and limited to a few priority programmes. Efforts to establish sound public policies that promote health and deal with determinants of ill-health are limited at best. Unregulated commercialization of both private- and public-health care is quickly becoming the norm for urban and, increasingly, for rural populations – a much bigger and more underestimated challenge to PHC’s values than the verticalism that so worries the international health community.

In most of these countries, the state has had, in the past, the ambition to run the health sector on an authoritarian basis. In today’s pluralistic context, with a multitude of different providers, formal and informal, public and private, only few have succeeded in switching to more appropriate steer-and-negotiate approaches. Instead, as public resources stagnated and bureaucratic mechanisms failed, laissez-faire has become the default approach to management of the health sector.

![Figure 6.3 Projected per capita health expenditure in 2015, low-expenditure, low-growth health economies (weighted averages)](image-url)
This has resulted in few or feeble attempts to regulate commercial health-care provision – not only by the private, but also within the public sector, which has, in many instances, adopted the commercial practices of unregulated private care. In such settings, government capacity often limits the extent to which new resources can be leveraged for improved performance. Health authorities are, thus, left with an unfunded mandate for steering the health sector.

Therefore, growing the resource base is a priority: to refinance resource-starved health systems; to provide them with new life through PHC reforms; and to re-invest in public leadership. Pre-payment systems must be nurtured now, discouraging direct levies on the sick and encouraging pooling of resources. This will make it possible to allocate limited resources more intelligently and explicitly than when health services are paid for out-of-pocket. While there is no single prescription for the type of pooling mechanism, there are greater efficiencies in larger pools: gradual merging or federation of pre-payment schemes can accelerate the build-up of regulatory capacity and accountability mechanisms.

In a significant number of these low-expenditure, low-growth health economies, particularly in sub-Saharan Africa and fragile states, the steep increase in external funds directed towards health through bilateral channels or through the new generation of global financing instruments has boosted the vitality of the health sector. These external funds need to be progressively re-channellled in ways that help build institutional capacity towards a longer-term goal of self-sustaining, universal coverage. In the past, the bulk of donor assistance has targeted short-term projects and programmes resulting in unnecessary delays, or even detracting from the emergence of the financing institutions required to manage universal coverage schemes. The renewed interest among donors in supporting national planning processes as part of the harmonization and alignment agenda, and the consensus that calls for universal access, represent important opportunities for scaling up investments in the institutional apparatus necessary for universal coverage. While reduced catastrophic expenditure on health care and universal access are sufficiently strong rationales for such change in donor behaviour, the build-up of sustainable national financing capacities also offers an eventual exit strategy from donor dependence.

Governments can do more to support the health sector in these settings. Low-expenditure, low-growth health economies allocate only a small fraction of their government revenue to health. Even in sub-Saharan African countries, which have made progress and allocated an average of 8.8% of their government expenditure to health in 2005, the Abuja Declaration target of 15% is still a long way off. Reaching that target would increase total health expenditure in the region by 34%. Experience of the last decade shows that it is possible to increase government revenues allocated to health rapidly. For example, following rising pressure from a broad range of civil society and political movements, India's general government expenditure on health – with a specific focus on primary health care – is expected to triple within the next five years. In a different context, the Ministry of Health in Burundi quadrupled its budget between 2005 and 2007 by successfully applying for funds that became available through debt reduction under the Enhanced Heavily Indebted Poor Countries (HIPC) initiative. On average, in the 23 countries at completion point for the HIPC and Multilateral Debt Relief Initiative (MDRI), the annual savings from HIPC debt relief during the 10 years following qualification are equivalent to 70% of public spending on health at 2005 levels. While only part of that money is to be directed to health, even that can make a considerable difference to the financial clout of public-health authorities.

Opportunities arise not only from increased resources. The preponderance of pilot projects is gradually being replaced by more systematic efforts to achieve universal access, albeit often for a single intervention or disease programme. These high visibility programmes, developed in relation to the MDGs, have revitalized a number of concepts that are key to people-centred care. Among them are the imperative of universal access to high quality and safe care without financial penalty, and the importance of continuity of care, and the need to understand the social, cultural and economic context in which all
In Mali, the primary care network is made up of community-owned, community-operated primary-care centres, backed up by government-run district teams and referral units. There is a coverage plan, negotiated with the communities, which, if they so wish, can take the initiative to create a primary-care centre according to a set of criteria. The commitment is important, since the health centre will be owned and run by the community: for example, the staff of the health centre, a three to four person team led by a nurse or a family doctor, has to be employed (and financed) by the local community health association. The community can make an agreement with the Ministry of Health to obtain technical and financial support from the district-health teams, for the launch of the health centre and the supervision and back up of its subsequent operation.

The model has proved quite popular, despite the huge effort communities have had to put into the mobilization and organization of these facilities: by 2007, 826 such centres were in operation (up from 360 10 years before), set up at an average cost of US$ 17 000. The system has proved resilient and has significantly increased the production of health care: the number of curative care episodes managed by the health centres has been multiplied by 2.1. The number of women followed up in antenatal care has been multiplied by 2.7 and births attended by a health professional by 2.5, with coverage levels as measured through Demographic Health Surveys in 2006 standing at 70% and 49%, respectively; DTP3 vaccination coverage in 2006 was 68%.

People obviously consider the investment worthwhile. Twice during the last 10 years, between 2000 and 2001 and 2004 and 2005, demand and local initiative for the creation of new centres was rising so fast that Mali’s health authorities had to take measures to slow down the expansion of the network in order to be able to guarantee quality standards (Figure 6.4). This suggests that the virtuous cycle of increased demand and improved supply is functioning. Health authorities are expanding the range of services offered and improving the quality – by encouraging the recruitment of doctors in the rural primary-care centres – while continuing their support to the extension of the network.

Box 6.2 The virtuous cycle of supply of and demand for primary care

In Mali, the primary care network is made up of community-owned, community-operated primary-care centres, backed up by government-run district teams and referral units. There is a coverage plan, negotiated with the communities, which, if they so wish, can take the initiative to create a primary-care centre according to a set of criteria. The commitment is important, since the health centre will be owned and run by the community: for example, the staff of the health centre, a three to four person team led by a nurse or a family doctor, has to be employed (and financed) by the local community health association. The community can make an agreement with the Ministry of Health to obtain technical and financial support from the district-health teams, for the launch of the health centre and the supervision and back up of its subsequent operation.

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health sector to do more with more. The unmet need in these countries is vast and making services available is still a major issue. It requires a progressive roll-out of health districts – whether through government services or by contracting NGOs, or a combination of both. Yet the complexities of contemporary health systems, particularly, but not only in urban areas, call for flexible and innovative interpretations of these organizational strategies. In many of Africa’s capitals, for example, public facilities of primary, and even secondary, level have almost or completely disappeared, and have been replaced by unregulated commercial providers. Creative solutions will have to build on alliances with local authorities, civil society and consumer organizations to use growing funds – pooled private pre-payment, social security contributions, funds from municipal authorities and tax-sourced funding – to create a primary-care offer that acts as a public safety net, as an alternative to unregulated commercial care, and as a signal of what trustworthy, people-centred health care can look like.

What eventually matters is the experience of patients accessing services. Trust will grow if they are welcomed and not turned away; remembered and not forgotten; seen by someone who knows them well; respected in terms of their privacy and dignity; informed about tests; and provided with drugs and not charged a fee at the point of service.

Growing trust can induce a virtuous cycle of increased demand and improved supply (Box 6.2). The gain in credibility that comes from instating such a virtuous cycle is key to gaining social and political consensus on investment in healthier public policies across sectors. Effective food security, education and rural-urban policies are critical for health and health equity: the health sector’s influence on these policies depends to a large extent on its performance in providing quality primary care.

Mobilizing the drivers of reform
Across all of the diverse national contexts in which PHC reforms must find their specific expression, globalization plays a major role. It is altering the balance between international organizations, national governments, non-state actors, local and regional authorities and individual citizens.

The global health landscape is not immune to these wider changes. Over the last 30 years, the traditional nation state and multilateral architecture have been transformed. Civil society organizations have mushroomed, along with the emergence of public-private partnerships and global advocacy communities identified with specific health problems. Governmental agencies work with research consortia and consulting firms as well as with non-state transnational institutions, foundations and NGOs that operate on a global scale. National diasporas have appeared that command substantial resources and influence with remittances – about US$ 150 billion in 2005 – that dwarf overseas development aid. Illicit global networks make a business out of counterfeit drugs or toxic waste disposal, and now have the resources that allow them to capture and subvert the capacity of public agencies.

Power is gravitating from national governments to international organizations and, at the same time, to sub-national entities, including a range of local and regional governments and non-governmental institutions.

This new and often chaotic complexity is challenging, particularly to health authorities that hesitate between ineffective and often counterproductive command and control and deleterious laissez-faire approaches to governance. However, it also offers new, common opportunities for investing in the capacity to lead and mediate the politics of reform, by mobilizing knowledge, the workforce and people.

Mobilizing the production of knowledge
PHC reforms can be spurred and kept on track by institutionalizing PHC policy reviews that mobilize organizational imagination, intelligence and ingenuity. The know-how to conduct policy reviews exists, but requires more explicit articulations. They need to refocus on monitoring such progress with each of the four interlocking sets of PHC reforms; on identifying, as they unfold, the technical and political obstacles to their advancement; and on providing the elements for course corrections, where necessary.
In a globalizing world, PHC policy reviews can take advantage of the emerging within- and across-country collaborative networks to build up the critical mass that can lead and implement the necessary reforms. Indeed, for many countries, it is not realistic to find, within their own institutions, all the technical expertise, contextual knowledge and necessary capacity for dispassionate analysis that PHC policy reviews require. Open, inclusive and collaborative structures, such as the Latin American observatory models, can go a long way in harnessing the diversity of national resources. Such models also make it possible to derive further benefits from international collaboration and to overcome the scarcities within a single nation’s capacities. Policy-makers today are more open to lessons from abroad than they may have been in the past, and are using them to feed national policy dialogue with innovative approaches and better evidence of what works and what does not. Embedding national institutions in regional networks that collaborate around PHC policy reviews makes it possible to pool technical competencies as well as information. Importantly, it can create regional mechanisms to get more effective representation in important but labour-intensive global bodies, with less strain on scarce national resources.

More structured and intensive inter-country collaboration around PHC policy reviews would yield better international comparative data on variations in the development of health systems based on PHC, on models of good practice and on the determinants of successful PHC reforms. Such information is currently often either absent, hard to compare or outdated. By building on networks of experts and institutions from different regions, it is possible to produce consensus-based and validated benchmarks for assessing progress and easier access to (inter)national sources of information relevant to monitoring primary care. This could make a big difference in steering PHC reforms. Various initiatives in this direction, such as the Primary Health Care Activity Monitor for Europe (PHAMEU), a network of institutes and organizations from 10 European Union Member States, or the Regional Network on Equity in Health (EQUINET), a network of professionals, civil society members, policy-makers, and state officials in Southern Africa, are promising steps in that direction.

There is a huge research agenda with enormous potential to accelerate PHC reforms that requires more concerted attention (see Box 6.3). Yet, currently, the share of health expenses devoted to determining what works best – to health services research – is less that 0.1% of health expenditure in the United States, the country that spends the highest proportion (5.6%) of

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**Box 6.3. From product development to field implementation – research makes the link**

The WHO-based Special Programme for Research and Training in Tropical Diseases (TDR) has been a pioneer in research to inform policy and practice. TDR-sponsored studies were the first to broadly document the efficacy of insecticide-treated bednets for malaria prevention in the mid-1990s, in multi-country, multi-centre controlled trials. Following introduction of the drug Ivermectin for onchocerciasis, or “river blindness”, control in the late 1980s, TDR, together with the African Programme for Onchocerciasis Control, initiated research on how best to get Ivermectin into mass distribution in the field. What evolved was a tested and fine-tuned region-wide system for “community-directed treatment” of river blindness, described as “one of the most triumphant public health campaigns ever waged in the developing world.”

Now, as the global health community moves away from vertical disease control, operational research is facilitating the shift. Recent TDR-supported large-scale, controlled studies involving 2.5 million people in 35 health districts in three countries have demonstrated that the community-directed treatment methods developed to combat river blindness can be utilized as a platform for integrated delivery of multiple primary health-care interventions, including, bednets, malaria treatment and other basic health-care interventions, with significant increases in coverage. For example, more than twice as many children with fever received appropriate antimalarial treatment, exceeding 60% coverage on average. Critical to both the funding and execution of such research are the partnerships fostered with countries in the region, as well as other public, civil society and private institutions. The vision now is to make implementation and operations research an even more important element of global research agendas, so that new products may finally begin to yield their hoped-for health impact through sounder primary health-care system implementation. Thus, the long-standing burden of deadly diseases, such as malaria, may be more effectively addressed – through global, regional and local knowledge-sharing and cooperation.
its health expenditure on biomedical research\textsuperscript{26}. As another striking example, only US$ 2 million out of US$ 390 million in 32 GAVI Health System Strengthening grants were allocated to research, despite encouragement to countries to do so. No other IS 5 trillion economic sector would be happy with so little investment in research related to its core agenda: the reduction of health inequalities; the organization of people-centred care; and the development of better, more effective public policies. No other industry of that size would pay so little attention to intelligence on the political context in which it operates – the positions and strategies of key stakeholders and partners. It is time for health leaders to understand the value of investment in this area.

**Mobilizing the commitment of the workforce**

Each of the sets of PHC reforms emphasizes the premium placed on human resources in health. The expected skills and competencies constitute an ambitious workforce programme that requires a rethink and review of existing pedagogic approaches. The science of health equity and primary care has yet to find its central place in schools of public health. Pre-service education for the health professions is already beginning to build in shared curricular activities that emphasize problem-solving in multi-disciplinary teams, but they need to go further in preparing for the skills and attitudes that PHC requires. This includes creating opportunities for on-the-job learning across sectors through mentoring, coaching and continuing education. These and other changes to the wide array of curricula and on-the-job learning require a deliberate effort to mobilize the responsible institutional actors both within and across countries.

However, as we have learned in recent years, the content of what is learned or taught, although extremely important, is but one part of a complex of systems that governs the performance of the health workforce\textsuperscript{4}. A set of systems issues related to the health workforce need to be guided to a greater degree by PHC reforms. For example, health equity targets for underserved population groups will remain elusive if they do not consider how health workers can be effectively recruited and retained to work among them. Likewise, grand visions of care coordinated around the person or patient are unlikely to be translated into practice if credible career options for working in primary-care teams are not put in place. Similarly, incentives are critical complements in ensuring that individuals and institutions exercise their competencies when engaging health in all policies.

The health workforce is critical to PHC reforms. Significant investment is needed to empower health staff – from nurses to policy-makers – with the wherewithal to learn, adapt, be team players, and to combine biomedical and social perspectives, equity sensitivity and patient centredness. Without investing in their mobilization, they can be an enormous source of resistance to change, anchored to past models that are convenient, reassuring, profitable and intellectually comfortable. If, however, they can be made to see and experience that primary health care produces stimulating and gratifying work, which is socially and economically rewarding, health workers may not only come on board but also become a militant vanguard. Here again, taking advantage of the opportunities afforded by the exchange and sharing of experience offered by a globalizing world can speed up the necessary transformations.

**Mobilizing the participation of people**

The history of the politics of PHC reforms in the countries that have made major strides is largely unwritten. It is clear, however, that where these reforms have been successful, the endorsement of PHC by the health sector and by the political world has invariably followed on rising demand and pressure expressed by civil society. There are many examples of such demand. In Thailand, the initial efforts to mobilize civil society and politicians around an agenda of universal coverage came from within the Ministry of Health\textsuperscript{29,30}. However, it was only when Thai reformers joined a surge in civil society pressure to improve access to care, did it become possible to take advantage
of a political opportunity and launch the reform\textsuperscript{27}. In just a few years, coverage was extended and most of the population was covered with a publicly funded primary-care system that benefit-incidence analysis shows to be pro-poor\textsuperscript{12,32}. In Mali, the revitalization of PHC in the 1990s started with an alliance between part of the Ministry of Health and part of the donor community, which made it possible to overcome initial resistance and scepticism\textsuperscript{34}. However, sustained extension of coverage only came about when hundreds of local “community health associations” federated in a powerful pressure group to spur the Ministry of Health and sustain political commitment\textsuperscript{35}. In western Europe, consumer organizations have a prominent place in the discussions on health care and public policies relating to health, as have many other civil society organizations. Elsewhere, such as in Chile, the initiative has come from the political arena as part of an agenda of democratization. In India, the National Rural Health Mission came about as a result of strong pressure from civil society and the political world, while, in Bangladesh, much of the pressure for PHC comes from quasi-public NGOs\textsuperscript{36}.

There is an important lesson there: powerful allies for PHC reform are to be found within civil society. They can make the difference between a well-intentioned but short-lived attempt, and successful and sustained reform; and between a purely technical initiative, and one that is endorsed by the political world and enjoys social consensus. This is not to say that public policy should be purely demand-driven. Health authorities have to ensure that popular expectations and demand are balanced with need, technical priorities and anticipated future challenges. Health authorities committed to PHC will have to harness the dynamics of civil society pressure for change in a policy debate that is supported with evidence and information, and informed by exchange of experience with others, within and across national boundaries.

Today, it is possible to make a stronger case for health than in previous times. This is not only because of intrinsic values, such as health equity, or for the sector’s contribution to economic growth – however valid they may be, these arguments are not always the most effective – but on political grounds. Health constitutes an economic sector of growing importance in itself and a feature of development and social cohesion. Reliable protection against health threats and equitable access to quality health care when needed are among the most central demands people make on their governments in advancing societies. Health has become a tangible measure of how well societies are developing and, thus, how well governments are performing their role. This constitutes a reservoir of potential strength for the sector, and is a basis for obtaining a level of commitment from society and political leadership that is commensurate with the challenges.

Economic development and the rise of a knowledge society make it likely, though not inevitable, that expectations regarding health and health systems will continue to rise – some realistic, some not, some self-serving, others balanced with concern for what is good for society at large. The increasing weight of some of the key values underlying these expectations – equity, solidarity, the centrality of people and their wish to have a say in what affects them and their health – is a long-term trend. Health systems do not naturally gravitate towards these values, hence the need for each country to make a deliberate choice when deciding the future of their health systems. It is possible not to choose PHC. In the long run, however, that option carries a huge penalty: in forfeited health benefits, impoverishing costs, in loss of trust in the health system as a whole and, ultimately, in loss of political legitimacy. Countries need to demonstrate their ability to transform their health systems in line with changing challenges as well as to rising popular expectations. That is why we need to mobilize for PHC, now more than ever.
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As nations seek to strengthen their health systems, they are increasingly looking to primary health care (PHC) to provide a clear and comprehensive sense of direction. *The World Health Report 2008* analyses how primary health care reforms, that embody the principles of universal access, equity and social justice, are an essential response to the health challenges of a rapidly changing world and the growing expectations of countries and their citizens for health and health care.

The Report identifies four interlocking sets of PHC reforms that aim to: achieve universal access and social protection, so as to improve health equity; re-organize service delivery around people’s needs and expectations; secure healthier communities through better public policies; and remodel leadership for health around more effective government and the active participation of key stakeholders.

This Report comes 30 years after the Alma-Ata Conference of 1978 on primary health care, which agreed to tackle the “politically, socially and economically unacceptable” health inequalities in all countries. Much has been accomplished in this regard: if children were still dying at 1978 rates, there would have been 16.2 million child deaths globally in 2006 instead of the actual 9.5 million. Yet, progress in health has been deeply and unacceptably unequal, with many disadvantaged populations increasingly lagging behind or even losing ground.

Meanwhile, the nature of health problems is changing dramatically. Urbanization, globalization and other factors speed the worldwide transmission of communicable diseases, and increase the burden of chronic disorders. Climate change and food insecurity will have major implications for health in the years ahead thereby creating enormous challenges for an effective and equitable response.

In the face of all this, business as usual for health systems is not a viable option. Many systems seem to be drifting from one short-term priority to another, increasingly fragmented and without a strong sense of preparedness for what lies ahead.

Fortunately, the current international environment is favourable to a renewal of PHC. Global health is receiving unprecedented attention. There is growing interest in united action, with greater calls for comprehensive, universal care and health in all policies. Expectations have never been so high.

By capitalizing on this momentum, investment in primary health care reforms can transform health systems and improve the health of individuals, families and communities everywhere. For everyone interested in how progress in health can be made in the 21st century, the *World Health Report 2008* is indispensable reading.
Team Leader’s Handbook

Global Health Education Program
The Christ Hospital/University of Cincinnati
Family Medicine Residency Program

Editors:
Andrew Bazemore, MD
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Christy O’Dea, MD
Director of Global Health Education
Lao-Tzu
I have three precious things which I hold fast and prize. The first is gentleness; the second is frugality; the third is humility, which keeps me from putting myself before others. Be gentle and you can be bold; be frugal and you can be liberal; avoid putting yourself before others and you can become a leader among men.

Napoleon Hill
The best job goes to the person who can get it done without passing the buck or coming back with excuses.

Andrew Carnegie
No man will make a great leader who wants to do it all himself or to get all the credit for doing it.

Peter Drucker
No executive has ever suffered because his subordinates were strong and effective.

Donald H. McGannon
Leadership is action, not position.

Joe Batten
The first task of a leader is to keep hope alive.

Henry Kissinger
Leaders must invoke alchemy of great vision.

John C. Maxwell
A leader is one who knows the way, goes the way and shows the way.

Harold S. Geneen
Leadership is practiced not so much in words as in attitude and in actions.

Arnold H. Glasgow
A good leader takes a little more than his share of the blame, a little less than his share of the credit.

Stephen R. Covey
Management works in the system; leadership works on the system.

Gen. H. Norman Schwarzkopf
Leadership is a combination of strategy and character. If you must be without one, be without the strategy.
Blaine Lee
The great leaders are like the best conductors - they reach beyond the notes to reach the magic in the players.

Arnold Glasgow
One of the tests of leadership is the ability to recognize a problem before it becomes an emergency.

Stephen Covey
Effective leadership is putting first things first. Effective management is discipline, carrying it out.

Unknown Author
A real leader faces the music, even when he doesn't like the tune.

Welcome to the second edition of the team leader’s handbook. The production of such a handbook recognizes the unique challenges and opportunity for skill-building facing the resident asked to lead a U.S. health brigade in remote areas of the world. We hope that information provided through this book will help to build the confidence necessary to take on this unique feature of residency training at U.C. Family Medicine.

We also hope that it will provide you with enough information on the remarkable partnership that is Shoulder to Shoulder, on Honduras and its people, and on ongoing project work to recognize the incredible value of your work, to feel invested in the project, and to be able to serve as an ambassador for the program.

Andrew Bazemore, MD               Christy O’Dea, MD
Philosophy of Global Health Electives conducted by the UC Department of Family Medicine

Developing countries enjoy a regular stream of energetic and talented health care professionals traveling to help the poorest communities in any way possible (Physician Service Opportunities Abroad. JAMA 1993; 270(5): 567-571). U.S. health centers and other volunteer health groups often bring with them eager medical students, residents, nursing students and allied health students for one to two weeks of medical service. These groups, by virtue of their broad community representation and influential reputation, often possess the ability to generate widespread support and raise the funds needed for their charitable endeavors.

Despite the talent, good will and infrastructure for raising funds and in-kind donations available for these short-term efforts, they rarely result in significant, sustainable improvement in the health status of poor communities. The reasons are complex, but a primary factor is that health centers and other volunteer groups together with their supportive communities do not have the understanding, knowledge or experience required to forge long-term relationships with needy communities in the developing world.

A long-term sustainable relationship opens possibilities for continuity of care, health promotion and disease prevention. Long-term relationships also lay a foundation for addressing health education, public health issues, economic development, agricultural development, improvement in schools and many other activities that impact the health of communities. It is this broader, comprehensive vision of sustainable community growth that poor communities deeply desire. This is consistent with the Honduran Ministry of Health priorities to promote community based health care initiatives. We desire to continue to develop an effective network of partnerships of health care professionals from U.S. health centers with educational and charitable goals to reproduce our successful long-term, sustainable health care and community partnership model in other communities in Honduras. We intend to link the goodwill and technical capacities of U.S. health centers with the industry and hope of poor rural Honduran communities, joining forces to work toward improvement of health status for the poorest of Honduras. We also hope to inspire U.S. and Honduran health care professionals to work in underserved communities. Ultimately, it is our goal to link multiple partnerships forming a network to interact with each other, the Honduran government and outside organizations to improve the health status of poor, rural communities in Honduras. We believe that this will also enhance the cultural competence of U.S. volunteer health workers.
Shoulder to Shoulder, Inc.: An Introduction

Shoulder to Shoulder is a private, non-profit 501(c)(3), non-governmental organization formed in Cincinnati, Ohio in 1996. It began providing health care services in western Intibucá in 1990, six years prior to its official incorporation. In the spirit of local empowerment, Shoulder to Shoulder worked with local community leaders in Santa Lucia to form Hombro a Hombro, a grassroots community-based, non-profit NGO registered in Honduras since 1996. Shoulder to Shoulder and Hombro a Hombro work in tandem to achieve a single mission: to develop educational and health programs to help poor rural communities in Honduras achieve sustainable development and improve the overall health and well being of its residents. We seek to address the health, education, economic, and social needs of isolated communities in the Western Intibucá region.

The three missions of Shoulder to Shoulder are:

1. To provide medical and dental care, nutrition services and community development for poor communities in rural Honduras.
2. To provide faculty supervised experiences for health care providers in an international setting that enhances skills in community health, tropical medicine, cross cultural medicine and working in resource poor environments.
3. To provide a setting for reflection and personal growth through service.

Shoulder to Shoulder receives in-kind assistance from the University of Cincinnati as well as financial assistance from private donors both corporate and individual. Over the past eighteen years, Shoulder to Shoulder has given more than 1500 U.S. citizens the opportunity to work side by side (“shoulder to shoulder”) with Hondurans committed to improving the health and well being of all in their communities. The total budget grew from $150,000 in 2004 to $1.7 million in 2008.

The Shoulder to Shoulder health clinic in Santa Lucia is a key component of our program, providing primary medical care, health education and community resources to the most needy. The clinic has modern exam rooms, an emergency room, and laboratory and radiology services. The Honduran physicians and nurses provide care to thousands of patients each year (approximately 50-80 patients per day). In addition, the dental clinic provides acute, restorative and preventive dentistry to the community. The clinic has a large attached dormitory for visiting brigade groups allowing for up to 40 individuals at a time. Apartments above the dormitory provide living space for the Honduran based staff.

- Shoulder to Shoulder also operates a clinic in Pinares, San Marcos de La Sierra, Intibucá. This clinic is staffed by a full time Honduran nurse and is supported by the Shoulder to Shoulder affiliate Thundermist Health Center (in Rhode Island) and Virginia Commonwealth University (VCU). There is a government physician in San Marcos, but great medical need in the villages in this area. The majority of people in the area are subsistence farmers and thus very poor. The Minister of Health has designated this area as one of their “underserved” areas which also attests to its great need. The government of Honduras has ranked San Marcos de La Sierra as the poorest municipality in all of Honduras.
Shoulder to Shoulder affiliates are academic health centers that send brigades on a regular basis to one community. They also manage ongoing public health programs at these sites. Other Shoulder to Shoulder affiliates include:

- The University of Rochester, San Jose, San Marcos de La Sierra, Intibucá
- The University of Pittsburgh, San Jose el Negrito, Yoro.
- Brown University, Guachipiloncito, Concepcion, Intibucá
- University of Wyoming, Agua Salada, Concepcion, Intibucá

Insert Map

Shoulder to Shoulder operates a number of public health projects.

**Yo Puedo** is an outreach program for fifth and sixth grade girls that currently functions in 10 schools in the villages surrounding Santa Lucia. The program was developed based on the vast body of research which shows that child health is greatly influenced by increased maternal education. The goals of the program are to encourage girls to stay in school, increase self esteem, and develop micro-business skills. Currently, the program is managed by a US volunteer. In the past, it has been managed by Peace Corp workers or the teachers themselves.

**The Madreguia Program** is a program that trains village women to function as community health workers. The women are trained on a variety of community health issues, including the importance of folic acid. The women then distribute folic acid to their neighbors on a monthly basis. The program currently functions in 10 villages around Santa Lucia, with over 100 madreguias, and over 1000 women receiving folic acid on a monthly basis. There are opportunities for brigades to meet with madreguias and provide education during their monthly meetings.

**The Water Filter Project** has distributed over 100 low cost, easy to use water filters to the poorest families in the area. The filters, developed by Potters for Peace, are made in Honduras and provided by a grant from Rotary International.

**The Library** was opened in 2007 to provide children with opportunities to read and learn outside of school. A new library was constructed in 2008 and provides twice weekly story hours, geography classes for older children, and internet access for the community.

**Cervical Cancer Screening Program** In October 2003, the cervical cancer screening program was started a program in Santa Lucia, Honduras using visual inspection with acetic acid. Except in the major cities of Honduras, there is little access to cervical cancer screening and the female population is largely unscreened. VIA (visual inspection with acetic acid) is a well studied method for cervical cancer screening in developing countries. This has been a brigade activity, in which women are screened in their own communities during field clinics, and then for those women with positive results, colposcopy is performed in the Santa Lucia clinic. Biopsy capabilities and cryotherapy are available. Women with dysplasia beyond the scope of cryotherapy are referred to La Esperanza. To date, more than 1000 women have been screened.
Past Projects

- Water Project: A geologist working for a private firm in Cincinnati has headed a project including our students and residents for determining new water sources for the community, and investigating sustainable water purification methods.
- Microbiological surveys of local water sources.
- Disease prevalence data from over 4,000 physician visits.
- A maternal depression survey was begun in October 2001.
- Educational programs for village health care workers, teachers and nurse midwives
- Mapping study
- MDS (minimum data set) and Rapid Catch surveys
- Diabetes clinics
- Feeding Program   Honduras suffers an immense burden of malnutrition. With U.S. funding support, parents of students built a cooking center at schools in 13 villages. Daily, local foods would be purchased and prepared by parents to ensure that each student received at least one nutritionally-balanced meal per day. Basic data on height, weight, and age for each student was collected at baseline, and sporadically over time since the creation of the program. The program is still in existence but funded by the World Food Programme.

The Ministry of Health Contract

In 2008, Shoulder to Shoulder, Inc signed a contract with the Honduran Ministry of Health to provide basic health services to the populations of Magdalena and San Antonio. Under this contract (“convenio”), Shoulder to Shoulder manages the health centers in the area, including the Centro de Salud in Magdalena, Centro de Salud in San Antonio, Cesar in Santa Teresa, and the Cesar in San Jose. Management includes supervision of the employees, provision of supplies and medications, and education of the personnel. In addition, the public health system, including supervision of health promoters, falls under the government contract. The health promoters are active in the communities, making home visits, following up on high risk families, providing community education, and monitoring for disease outbreak. (A Centro de Salud is literally, a “health center” usually staffed by a doctor and nurse. A Cesar is a smaller health center, usually staffed by a nurse only.)

In July 2009, Shoulder to Shoulder is projected to add the population of Santa Lucia to its contract, bringing the total population under contract to approximately 16,000 people. Concepcion is projected to be added to the contract in January 2010, with the opening of a newly constructed health center. San Marcos de La Sierra is also projected to be added in January 2010.

The government contract gives brigades a unique opportunity to participate in the health system of the area. Brigade activities directly contribute to the public health needs of the area, and fulfill requirements of the contract. This provides opportunities to participate in health fairs, community clean up days, provision of care at STS-managed health centers, participation in census taking activities, and evaluation of programs.
Shoulder to Shoulder has developed a database to follow all patients within its system. All patients have a unique “carnet” card and number which is noted on all paperwork. All patient encounters, including census data, clinic visits, anthropometric data, and participation in activities, are monitored in this database.

Because of the government contract, there is extensive paperwork that needs to be completed. As visiting health care providers, it is important that this paperwork is filled out completely and adequately. Ideally, this paperwork should be discussed either before arrival, or on the first evening of orientation in Santa Lucia. Paperwork that should be addressed with the group beforehand includes prenatal and delivery forms, encounter forms and coding, and daily patient log forms. All government forms should be completed in Spanish. In patient charts, Spanish is ideal, but only required for pregnant women and children under 5.

**HONDURAS: A Brief Introduction**

Intro: Part of Spain’s vast empire in the New World, Honduras became an independent nation in 1821. After two and one-half decades of mostly military rule, a freely elected civilian government came to power in 1982. During the 1980s, Honduras proved a haven for anti-Sandinista contras fighting the Marxist Nicaraguan Government and an ally to Salvadoran Government forces fighting against leftist guerrillas. The country was devastated by Hurricane Mitch in 1998, which killed about 5,600 people and caused approximately $2 billion in damage.

**Population:** 6,823,568 (July 2004 est.)

**Age structure:**
- 0-14 years: 41.2% (male 1,434,555; female 1,376,216)
- 15-64 years: 55.1% (male 1,866,219; female 1,896,027)
- 65 years and over: 3.7% (male 118,404; female 132,147) (2004 est.)
Median age: total: 19 years  
    male: 18.6 years  
    female: 19.4 years (2004 est.)

Population growth rate: 2.24% (2004 est.)

**Economy:** Honduras is the third poorest country in the Western Hemisphere. The 2001 GNP per capita is only $740 per year placing it in the World Bank classification system in the poorest quartile. It has an extraordinarily unequal distribution of income and massive unemployment, is banking on expanded trade privileges under the Enhanced Caribbean Basin Initiative and on debt relief under the Heavily Indebted Poor Countries (HIPC) initiative. While the country has met most of its macroeconomic targets, it has failed to meet the IMF’s goals to liberalize its energy and telecommunications sectors. Growth remains dependent on the status of the US economy, its major trading partner, on commodity prices, particularly coffee, and on reduction of the high crime rate.

*Source: www.cia.gov*

**Health Conditions in Honduras:**

Health statistics are not completely reliable, for example, in 1990, the Pan American Health Organization (PAHO) estimated that 44.2 % of the deaths were unreported. Nonetheless, the following information illustrates the health and socioeconomic challenges in Honduras:

<table>
<thead>
<tr>
<th></th>
<th>Honduras</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality (deaths/1000)</td>
<td>36</td>
<td>7</td>
</tr>
<tr>
<td>From Perinatal period:</td>
<td>20.6%</td>
<td></td>
</tr>
<tr>
<td>From Intestinal infectious diseases:</td>
<td>28.2%</td>
<td></td>
</tr>
<tr>
<td>From Respiratory infections:</td>
<td>21.8%</td>
<td></td>
</tr>
<tr>
<td>Maternal Mortality (deaths/ 100,000 live births)</td>
<td>221</td>
<td>8</td>
</tr>
<tr>
<td>From Hemorrhage:</td>
<td>32.8%</td>
<td></td>
</tr>
<tr>
<td>From Infections:</td>
<td>20.7%</td>
<td></td>
</tr>
<tr>
<td>From Hypertensive disease:</td>
<td>12.3%</td>
<td></td>
</tr>
</tbody>
</table>

Households below poverty line 75.6%

*The health situation in rural areas is even worse:*

Malnutrition among school children ages 6-9: 44.6% (vs. 26.2% in urban areas)
Underemployment: 34% (vs. 17% in urban areas)
Adequate Housing: 16%
Access to drinking water, excreta disposal and electricity: 19%
Fertility Rate: 6.3 children per household (vs. 3.9 in urban households)

*Source: World Development Indicators 2001 World Bank and Health in the Americas 1998, Pan American Health Organization*
Santa Lucia and Intibucá: The Hombro a Hombro Clinic

Santa Lucia – is the site of the Clinica Hombro a Hombro (Shoulder to Shoulder Clinic). Teams from U.C. and other collaborating medical schools and individuals have been traveling to this site since 1990 to provide health care to this once very impoverished region. Preventative (and some restorative) dental care has been provided to this area for about 5 years as well. Research and/or community development projects may also be undertaken in Santa Lucia. Sleeping arrangements here are in a dorm. There is a kitchen and a large meeting/dining room in the dorm. There is electricity – when working. It often goes out during the rainy season.

- Santa Rita – is about a 60 minute drive from Santa Lucia. There is an established clinic building in that will open in July 2009 with the Santa Lucia government contract. The region suffers from a lack of healthcare and deep poverty. Electricity is provided in those areas whose villagers could afford to pay for the Honduran government hook up fee which is exorbitant for them (about 5 years wages for 4-5 households).

- San Antonio – is about a 60 minute drive from Santa Lucia. There is a STS-managed Centro de Salud with a physician and two nurses. Brigade members may be sent to cover the government personnel in this health center when they have trainings, vacation, etc.

- Santa Teresa is about 90 minutes from Santa Lucia. It is a small STS-managed Cesar which has a Honduran nurse.
- Magdalena is a 10 minute car ride or 30 minute walk from Santa Lucia. There is a STS-managed Centro de Salud with a Honduran physician and nurse.

- San Jose, San Antonio is a 30 minute drive from Santa Lucia. The STS-managed Cesar is staffed by a Honduran nurse and usually visited by a Honduran doctor on a weekly visit.

Preparing the team: Travel Medicine

Members of your team will likely have questions regarding health related preparations for travel to Honduras. For information specific to Honduras, you can visit [www.cdc.gov](http://www.cdc.gov). For additional assistance or questions, feel free to email Dr. Christy O’Dea (Christy.odea@yahoo.com).

**Recommended vaccinations for Brigades to Santa Lucia:**

- **Hepatitis A** *Recommended for:* all travelers.

- **Typhoid** *Recommended for:* prolonged stays or “adventurous eaters”.

- **Hepatitis B** *Recommended for:* all health care workers; prolonged stays; frequent short stays in this or other high risk countries; adventure travelers; the possibility of acupuncture, dental work, or tattooing; the possibility of a new sexual partner during stay; and travelers with high potential to seek medical care in local facilities. Consider for short stays in risk-averse travelers desiring maximum pre-travel preparation. Increased awareness is recommended regarding safe sex and body fluid/blood precautions.

- **Rabies** Risk should be presumed to occur in most parts of the country. *Recommended for:* prolonged stays with priority for young children. Also recommended for shorter stays at locations more than 24 hours travel from a reliable source of post-exposure rabies vaccine; occupational exposure; all adventure travelers, hikers, cave explorers, and backpackers. Consider for risk-averse travelers desiring maximum pre-travel preparation.

- **Influenza** Flu is transmitted year round in the tropics and all travelers are at increased risk. *Recommended for:* all travelers over age 50; all travelers of any age with any chronic or immunocompromising conditions. Consider for any traveler wishing to decrease risk of influenza or non-specific respiratory illness. Consider anti-virals as standby therapy for those inadequately immunized.

- **Routine vaccinations** (adults only)
  - **Tetanus/Diphtheria/Pertussis** (all countries)—Adequate primary series plus one dose of Td within the last 10 years.
  - **Measles** (all countries)—Indicated for those born in 1957 or later (1970 or later in Canada) without history of disease or of 2 adequate doses of live vaccine at any time during their life. Many countries (including the U.K.) recommend that adults need to have had only 1 countable dose at any time during their life.
  - **Polio** - Adult polio boosters are unnecessary for travel anywhere in South and Central America.
  - **Pneumococcal** (all countries)—All adults over 65 and those with chronic disease or compromising conditions.
  - **Varicella** (all countries)—Consider for long-term travelers with no history of the disease.

**Malaria Risk** Risk (predominantly *P. vivax*) exists throughout the year in rural areas including diving resorts on the Caribbean coast and the Bay Islands (Roatan and others) and within the municipalities of Tegucigalpa and San Pedro Sula. There is a very low risk of malaria in Intibuca.
Malaria Prophylaxis: Recommend evening and nighttime insect precautions in risk areas. The medicine chloroquine protects against malaria in this area, however there is a very low risk of malaria in Intibucá.

Insect Precautions  Although the risk of malaria is very low in and around Santa Lucia, there is a small risk of Dengue Fever in the area. Dengue Fever is a viral illness transmitted by the daytime biting Aedes aegypti. Therefore, insect precautions, including the use of insect repellent with DEET (<30-50%) are encouraged.

Traveler’s diarrhea: High risk throughout the country including deluxe accommodations in major cities. Tap water is unsuitable for drinking. Drink only bottled or boiled water. Eat only hot food in restaurants. Avoid uncooked vegetables and fruits. Recommend that all brigade members bring antibiotics for traveler’s diarrhea, such as ciprofloxacin, rifaximin, azithromycin, or other floxin. In addition, it is wise to bring an antidiarrheal, such as loperamide, to be taken along with antibiotics.

OTHER:

- San Pedro Sula is considered the HIV capital of Central America. 8% of sex workers in the capital city are estimated to be HIV positive. Extra time reinforcing HIV/STD concepts is recommended during the pre-travel consultation.
- Leishmaniasis (cutaneous), transmitted by sandflies, is widespread in rural areas. Recommend insect precautions.
- Chagas' disease occurs in rural areas; risk to travelers is unknown but is thought to be negligible. Avoid overnight stays in houses constructed of mud, adobe brick, or palm thatch. Avoid blood transfusions not assuredly screened for Chagas' disease.
- Violent crime, including sexual assault and carjacking, occur in tourist areas and foreigners have been targeted. Advise extraordinary vigilance and strict adherence to personal security strategies at all times.
- In general, the rural communities of Intibucá are safe for travel. It is recommended that brigade members leave in pairs, and do not leave the clinic premises after dark.
- San Pedro Sula and El Progreso have more crime. It is recommended that before leaving the hotel, check in with your Honduran brigade leader. Travel outside the hotel after dark is not recommended (even in groups).

Packing & Requirements for Participation and Travel to Honduras

**PROPOSED CHECK LIST OF PERSONAL ITEMS**

<table>
<thead>
<tr>
<th>Item</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure cuff</td>
<td>-</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>-</td>
</tr>
<tr>
<td>Oto-ophthalmoscope</td>
<td>-</td>
</tr>
<tr>
<td>Canteen/Water bottle</td>
<td>-</td>
</tr>
<tr>
<td>Camera with charger and cord to download photos</td>
<td>-</td>
</tr>
<tr>
<td>Flashlight or Head lamp</td>
<td>-</td>
</tr>
<tr>
<td>Personal medications, including Cipro or other antibiotic for traveler’s diarrhea</td>
<td>-</td>
</tr>
<tr>
<td>Passport, airline tickets, money -- always on your person - a waist pack is a good means of carrying these items. A COPY OF YOUR PASSPORT should be placed in all of your luggage</td>
<td>-</td>
</tr>
</tbody>
</table>
An airport tax of approximately $34 is needed to leave the country, this may be paid in Lempira, or dollars, but not by credit card.

Very little cash is needed during the trip. All meals and hotel expenses are covered by the brigade fee. Usually not more than $50 is needed for snacks and drinks. (A visit to a souvenir shop on the last day usually occurs, and they take credit cards.)

Personal journal, if desired
Pocket translation guide/dictionary
Toilet tissue/Kleenex
Ear plugs
3-5 days of clothing. Comfortable, casual clothes area best. You may wish to bring scrub shirts in which to work. Shorts are not acceptable for work in the clinic. Laundry services are available.
Good walking shoes
Flip-flops for the shower
Rain gear
Towel/washcloth
Toiletries
Sheet(s)
Inflatable pillow or pillow case which can be stuffed with towels or clothes
Insect repellant (not more than 30-50% DEET as active ingredient)
Lightweight sweater
Bathing suit/suntan lotion

The majority of your check-in baggage will need to contain medicines and supplies. You should plan on the possibility of not having your check-in baggage for the first couple of days (worst case scenario). All personal, valuable items should be kept in your carry-on (including at least one change of clothing and your toiletries).

Consular Information/State Department updates

- Honduras Consular information sheet webpage:

- REGISTRATION/EMBASSY LOCATION: Americans living in or visiting Honduras are encouraged to register at the Consular Section of the U.S. Embassy in Tegucigalpa and to obtain updated information on travel and security within Honduras. (This will be done by Mo Jennings for the entire brigade.)

- The U.S. Embassy and Consulate are located at:
  Avenida La Paz in Tegucigalpa, Honduras
  Fax: 011-504-238-4357
  Web site: http://www.usmission.hn/
  Telephone: 011-504-236-9320 or 011-504-238-5114
  For information on services for U.S. citizens, please ask for ext. 4400.

- The Consular Agency in San Pedro Sula is located at:
  Banco Atlantida Building - 8th Floor
  San Pedro Sula, Honduras
Telephone: 011-504-558-1580
The Consular Agent is available during limited hours to accept U.S. passport applications for adjudication at the Embassy in Tegucigalpa, perform notarial services and assist U.S. citizens with emergencies. Please call for office hours. The Consular Agent does not provide visa information or services.

- Evacuation Insurance is included in the brigade fee and provided for all brigade members. Before the brigade, a proof of insurance card will be emailed to all brigade members. Each should print it out and carry it with them during the brigade. It includes a phone number to be used in case of emergency. The company should be called before any transport is arranged.

Questions about brigade work and activities

Goals for the Brigade participant: It is important to view your trip as having three principle objectives:

1. To help- you can do this in many ways- seeing patients, teaching Honduran staff, initiating new projects, installing new equipment, organizing the pharmacy or even tidying up the facilities. There are many ways because there are many needs. You may also help by bringing comfort or joy to poor people who seldom are recipients of such commodities.

2. To learn: Learn how to practice in resource poor areas, learn how to rely on your physical exam skills, learn how to practice in a different culture, learn a different culture, etc.

3. To reflect: Why do I have what I have? Who are my neighbors? What can I do at home and abroad to alleviate suffering? What are my obligations to the poor? And many more similar questions- Initiate such conversations with those who are most like you and those are least like you.

Cultural competence This is a topic that should be addressed in country during nightly discussions. In a nutshell, visiting providers should have the following goal: be aware of, sensitive to, and knowledgeable about the Honduran culture. Until you start achieving this goal, simply be respectful, a good listener rather than talker, and don’t for a moment think that Americans have all the right answers….especially for Hondurans.

Working well with translators This is another topic that should be addressed in country during the evening sessions, preferably early in the trip. Key points:

Recognize the power and importance of the translator.

1. Ask the translator to translate word for word in both directions.

2. Try to speak at least a few words of greeting in Spanish to start the encounter as a way of creating a comfortable atmosphere.

3. Talk to the patient, not the translator; using short sentences and simple words.

Your Responsibilities as Team Leader

1. Set the Tone. Your attitude, manner, and style will set the tone for the rest of the brigade members. By exhibiting a confident, respectful, and energetic attitude, the brigade members will feel the same.

2. Make an Effort to Know Brigade Members Individually During the first few days of the global health course, and during the brigade, introduce yourself to each
member of the brigade, and discuss their individual goals for the trip. Think about each individual’s strengths and weaknesses.

3. **Encourage Teamwork.** Consider planning a team building activity during the global health course or early in the brigade to encourage brigade members to get to know each other. Remind brigade members early and often that all brigade activities may not involve direct patient care, but that all activities are important to the organization.

4. **Be available.** Reach out to brigade members before the trip, and make sure they know they may contact you in case of questions or concerns.

5. **Communicate.** You are in a unique position to communicate between the on the ground Honduran staff and the brigade members. Arrange with the Honduran staff to have regular meetings (probably each afternoon or evening) to discuss details for the following days.

6. **Be Prepared.** The brigade team leaders should bring along their own emergency preparedness box, including: GPS units, cell phones, HIV prophylaxis, and influenza prophylaxis (If deemed necessary).

7. **Manage the Details**
   - **Brigade Activity Planning**
     - Designate one person to communicate with Honduran staff to assess needs on the ground and possible brigade activities.
     - Months prior to the trip, meet with the other team leaders and interested faculty and discuss possible projects and activities.
     - Designate a contact person for each project.
     - Expect frequent communication with the on the ground staff in Honduras in the weeks and months prior to the trip.
     - Consider making a provisional schedule (Consider use of template in Appendix C). Try to make sure that there are a variety of activities for brigade participation: clinical activities, public health projects, and home visits. (Consider use of template seen in Appendix H)
     - Consider a fun activity for Sunday (waterfall, river).
     - You should strongly consider including medical education for the Honduran staff in your brigade planning.
   - **Packing**
     - Remind brigade members about needed supplies before the trip.
     - Designate an area to collect supplies before packing.
     - Inform brigade members that they will be bringing supplies with them and how much space they have for their own packing.
     - Using the methods explained on the website, pack bins for the flight.
     - Distribute bins to brigade members, clearly explaining that each is responsible for the bin assigned to him/her.
     - Keep a list of what is packed in each bin, and who has each bin.
   - **Global Health Course**
     - You may be asked to give a talk during the Global Health Course.
     - You are encouraged to attend those lectures that you did not attend during the previous course. However, it is understood that you will have planning and packing that may keep you from attending all of the lectures.
   - **Traveling**
     - Encourage the group to stay together when traveling.
     - Be sure all brigade members are present before leaving from one place to the next.
     - Work with Honduran staff to assign brigade members appropriately to hotel rooms (Appendix G).
   - **Education**
     - Work with your faculty to prepare short nightly discussions following a brief case conference.
✓ Designate team leaders or faculty to lead case conference each night. Topics should include: Common medications used in Santa Lucia, Cultural beliefs of Health and Illness in Honduras, How to work with Interpreters, Common illnesses seen in Santa Lucia, and Dengue.

- **On the Ground Orientation** During the first day in Santa Lucia, arrange for a clinic tour and orientation. Orientation with the brigade should include:
  ✓ Introduction of all Honduran staff
  ✓ Introduction of all brigade members
  ✓ Introduction of translators
  ✓ Ground Rules (see Appendix A)
  ✓ Orientation to the government system and forms
  ✓ Orientation of translators

- **Scheduling**
  ✓ Communicate each afternoon with the designated Honduran Staff regarding the following day’s activities. Make sure to discuss transportation and lunch!
  ✓ When scheduling, make sure that each brigade member has a variety of experiences.
  ✓ Ensure that each team that goes out has a GPS unit and cell phone with phone numbers in case of emergency. (Consider use of template in Appendix I)

- **“Despedida” and Talent Show** This is a tradition that is fun to continue. Work with the Honduran staff to organize a dinner and dance with the local committee on the last night of the brigade. This is a good time to thank your cooks and staff. (Small gifts are always appreciated.) Inform brigade members early in the brigade that there is a talent show so they can prepare.

- **Evaluation**
  ✓ Before you leave Honduras, please fill out the brigade summary form and brigade evaluation form and return them to Christy O’Dea, MD.
  ✓ You may consider asking brigade members to complete a brigade evaluation form as well.
Appendix A: Ground Rules

1. **Water Conservation** is extremely important. There is a finite amount of water for the entire village, and overuse of water from brigades may mean that others in the village go without water. Therefore the following techniques are important:
   - “When its yellow let it mellow, when its brown flush it down”
   - Army showers: stand under the shower, get wet, turn off the water, soap up, then turn the water on again to rinse off.
   - Gray water use: When showering, stand in a large basin to collect the water. Use this water later on to flush the toilet. Simply pour the water in the toilet bowl to flush.
   - Finally, do not toilet paper in the toilet!

2. **Water and Food Safety** The cooks who work for Hombro a Hombro are specially trained to prepare food so that it is safe for North Americans. Anything they put on the table for you is safe. The water that comes out of the tap is not safe. You may drink from water from the water cooler in the comedor. Water from the tap is passed through a large sand filter in the back of the kitchen to fill the jugs for the water cooler. In addition you may drink water from the bucket filters that are in the comedor. In general, the small restaurant in front of the clinic (El Chadai) is safe, although we can’t guarantee the safety of the food. Other restaurants in town should be avoided.

3. **Internet** The internet is crucial to the functioning of the clinic. Unfortunately, the internet system has limited bandwidth, and going over the limit will cause a shutdown of the system. Therefore, limited use of the internet by brigade members is very important. The Honduran staff will inform the brigade which computer may be used. It is important that brigade members know that they may only check email. The following is prohibited: downloading or uploading photographs or videos, facebook, my space, utube, checking websites that use many pictures or streaming video.

4. **Quiet Time** The apartments above the dormitory are the residences for the Honduran staff. This is their home, and we as brigade members are guests in their home. We should be respectful of this. There should be a quiet time recognized after 10 pm.

5. **Alcohol** Santa Lucia is a dry town, and no alcohol is sold in town. As representatives of Shoulder to Shoulder and our countries, we want to show our best face and be good examples. Therefore, no alcohol is allowed during the brigade in Santa Lucia.

6. **Laundry** There are women who will wash your laundry for a small cost. They will pick up your laundry each morning at 7 am, and bring it back in the afternoon. If you won’t be around around 5 pm, leave your money with someone to pay the ladies and pick up your laundry.
Appendix B: Pearls from Previous Team Leaders

- Pre-trip planning and communication with brigade participants
- Participation/contributions to the I.H. course before your trip (if applicable)
- Organizing/helping with packing
- Working with Faculty participants, faculty leaders
  - Be confident—act like you know what is happening, even when you don’t
  - Encourage, facilitate, coordinate, problem-solve
  - Listen well, communicate to the group often
  - Depend on your Honduran staff leader—ask for help, ask questions
  - Use humor when you can with the group
  - Think 1-2 days ahead and frequently communicate plans/schedules with the group
  - Frequent reminders about water, showers, working together
- Organizing the group at the airport
  - Consider head count
  - Check head counts
  - Stick together as a group through the airports. Timing is often tight for the connections. Gather after exiting the plane, stick together until the gate.
  - At the Houston airport, may buy water and snacks for the first few hours in San Pedro
  - Inform everyone that they will need to complete customs forms on the plane, but there is no need to declare anything on the form.
- ...through customs
  - Plan for a few Spanish speakers to be at the front of the line at customs, explain about the brigade and donated medical supplies.
  - Identify any missing luggage, check inventory lists, and put in a claim at the airport for any missing bags. Put Marvin’s cell phone number on the claim.
  - As soon as the group is gathered outside of customs, move out into the main airport terminal and to the front “porch” of the terminal and look for Marvin.
  - Make sure everyone keeps their carry on bafr with them—everything they need for the next 24 hours. All checked bags will not be seen again until Santa Lucia
- ... once on the ground in Honduras
  - Count heads on the bus!
  - Announce the schedule for the Afternoon
  - About 2-3 hours to Siguatepeque
  - Lunch in Siguatepeque (good grocery store, sells vanilla—good souvenir)
  - Another 2 hours to La Esperanza (very winding roads, consider Dramamine)
- ... the first night in the hotel in La Esperanza
  - Check with Marvin about schedule/dinner
  - Work with Marvin to assign hotel rooms
  - At dinner, discuss schedule for next morning (Breakfast, encourage walk through market, set time for bus)
  - Remind all to keep passport and money with them at all times.
  - Usually there will be a visit to the district hospital
- On the road to Santa Lucia
  - a Stop in Pinares for bathroom, snacks. (Coffee sold is good souvenir)
  - Stop at clinic in Concepcion for tour and bathroom break—no drinks
  - Consider stop in Camasca to visit health center—need to set up with Marvin ahead of time
  - Long, unpaved road through the mountains to Santa Lucia, consider Dramamine!
- Arrival in Santa Lucia
  - Greet Staff first—discuss plan for unpacking, tours, sleeping quarters, schedule for afternoon
  - Be careful about which bins can be unpacked and which should be delivered before unpacking
  - Formulate a schedule for Monday
  - Gather the group for introductions, meet interpreters, and discussion of ground rules. Discuss schedule for evening and Monday. Invite Honduran staff to participate.
- Weekdays in Santa Lucia
  - Post schedules each night for following day
  - Communicate frequently with the group about plans and working together
• Organizing the field clinic
  o It takes roughly 10-15 persons to run a small field clinic, more if the village is very large. Size should be determined based on estimates of how many persons will attend the clinic (which our Honduran partners can help to assess in advance).
  o MY OPINION IS THAT DELEGATION NEEDS TO BE WELL THOUGHT OUT - ONE PERSON AT LEAST FOR THE DURATION OF THE TRIP - EVEN IF THEY ARE NOT ON EVERY FIELD EXPERIENCE. BETTER NOT TO HAVE A FIRST TIMER OR CAUTIOUS PERSON IN CHARGE ALONE. USUALLY BETTER TO HAVE A TECHNICAL PERSON AND A LOGISTICS PERSON. MEET AHEAD OF TIME - MAKE OTHERS EXPERTS LIKE YOU!

• Organizing/motivating people in the Santa Lucia clinic to do various tasks, to carry their load
  o The mood and attitude of the team leader affects the entire brigade. A team leader who is eager to help out in any way, will encourage brigade members to do the same. Likewise, a disinterested team leader will discourage the brigade as a whole.
  o (HECK) It takes roughly 8-12 persons to run the Sta Lucia clinic
  o (HECK) how to engage non-medical people and how to spot potential problem participants and how to deal with them: BASICALLY THINK ABOUT IT! ASK FREQUENTLY DURING THE FIRST TWO DAYS. FOR NON-MEDICAL PEOPLE FIND OUT WHAT THEIR SKILLS ARE - MATCH THEM WITH A NEED. REASSESS FREQUENTLY, LET PEOPLE KNOW THAT INITIATIVE IS GOOD. THE PROJECT IS LIKE A LARGE LANDSCAPE MURAL - EVERYONE IS AN ARTIST AND CREATES A PART OF THE PICTURE.

• Managing resources (limited water supply, etc.)
• Managing illness among brigade members (Diarrhea, etc)
• Maintaining Safety for brigade participants
  o No more than 6 brigade members in the back of a truck, it is preferable to fill up the cab of a truck, and then put people in the back of a truck
• Working with Faculty participants, faculty leaders
• Weekend
  o Plan something fun for the weekend (skit night, movie night, etc)
  o Check with Marvin about possibilities - hike, waterfall
• Evening Discussions
  o Think about what to accomplish each evening when the group gathers, have a simple agenda, ask brigade members to share experiences from the day.
  o Ask Honduran staff to participate - either presenting a topic or listening and contributing
• Departure
  o Emphasize safety - stay in the hotel in El Progreso!
  o Communicate plans frequently
  o Stop at IMAPRO, souvenir shop that takes credit cards!
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Appendix D: Brigade Summary Template and Example

Brigade Summary Form

University
__________________________________

Dates
__________________________________

Honduran Home Base
__________________________________

Mission
__________________________________

Introduction/Overview

- Brigade: The ______ Brigade consisted of __ members, including ___ Residents, ___ Nursing students, ___ Medical Students, ___ Faculty, and ___ Others
- Team Leaders ______________________________________

Project Summary (project leaders are encouraged to write a one page summary including: objectives, methods, and results, communities involved, and contact person)

- ...
- ...
- ...

Patient Care Summary (be sure to include any specialty services offered)

- Main Location:

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<th># Patients Seen</th>
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- Other Sites:
Community Education Offered
• ...
• ...
• ...

Lectures and Didactics Offered
• ...
• ...
• ...

Follow Up Required
• Patients requiring follow up
• Projects requiring follow up

Suggestions for Future Brigades
• ...
• ...
• ...

February 2004 Brigade Synopsis: (Composed by Eric Byman, Suzanne Gaudreault , Julia Reitz)

The February 2004 brigade to Honduras was a tremendously eventful and largely successful trip. Our group included residents, medical students, attending physicians, a dentist, nurses, translators, and numerous other Honduran and American workers. The resident Team Leaders were Drs. Eric Byman, Suzanne Gaudreault, and Julia Reitz. We were based at the clinic in Santa Lucia and sent large teams to the outlying villages of San Jose, El Aguila, and Santa Rita for daily field clinics.

Thanks to our Honduran partners, the trip was filled with moving and fabulous learning experiences. Our teamwork and clinical skills were put to use with numerous patients, including a gun shot victim, a severely dehydrated toddler, a new mother and baby, and several people in need of specialty services for whom we coordinated hospital care. One particularly touching experience was the case of a 7 year old boy with severe malnutrition who presented to one of the field clinics. He and his family were transported to Santa Lucia where they were treated and nurtured over the course of the week by numerous brigade members who each employed their own special gifts in caring for this boy and his family.
In addition to the plentiful clinical activity, members of our group worked on several interesting research projects. These included:

- **GPS mapping of the area to demonstrate how geography affected where people went for their medical care.** More info can be received from Andrew Bazemore or Jonathan Baker
- **A study attempting to correlate dehydration and headaches:** More info can be received from Jeff Schlaudecker
- **A preliminary study on sexually transmitted disease screening in women.** More info can be received from Julie Thurlow or Jill Huppert
- **And a survey of community knowledge of women’s health issues and utilization of women’s health services.** More info can be received from Andrew Bazemore or Elizabeth Cavallero

Perhaps the greatest testament to the success of the Shoulder-to-Shoulder program was the relatively slow pace of work at the Santa Lucia clinic. Over the years that the clinic has been in place, the local populace has become accustomed to increasingly high-quality care from the Honduran doctors who man the clinic year-round; American doctors are no longer the only source of modern medicine. Still, as our field clinics and GPS surveys showed, there are still many people at remote sites for whom more can be done; Shoulder-to-Shoulder’s mission is just beginning.
Appendix F: Santa Lucia Service Area Map
Assigning hotel rooms to all brigade members for your team’s overnight stays coming into and out of Honduras is important. You will enter Honduras in either San Pedro Sula or Tegucigalpa, then drive to La Esperanza and usually spend the night there on the day of arrival. The team leader should coordinate with Honduran Staff in advance and arrive onsite with a table such as is seen below. Take charge at the check in desk, and direct traffic from there.

**HABITACIONES – Honduras Hotel Maya**

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### Daily Brigade Worksheet

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Appendix J: Proposed Timeline for October Trip

January
- Set dates and confirm/reserve with Shoulder to Shoulder
- Send out emails to all interested parties informing them of dates
- Begin to assemble list of brigade members (Include name, email and Spanish level)

March–April
- Review brigade list with Judy Flick and Sherry Weathers
- Assemble waiting list if needed

June
- Send out informational letter to all brigade participants
- Confirm brigade list

July
- Finalize brigade list
- Paperwork and brigade fees due
- First meeting with team leaders, and faculty advisors
  - Discuss goals, project interests
  - Divide duties
- Contact Honduran staff and discuss project needs
- Contact medical and non-medical brigade members with special interests

August
- Contact Global Health course directors-discuss team leader activities during course
- Continue outlining possible schedule
- Remind brigade members about travel preparations (immunizations, collection of supplies)

September
- Continue preparations for projects
- Inform brigade members about selected suggested readings
- Remind brigade members about supplies and travel preparations
- Continue communications with Honduran staff regarding project and educational needs
- Contact brigade members to prepare particular educational talks

October
- Finalize brigade schedule with Honduran staff
- Prepare tentative schedule of activities and evening discussions
- Decide on packing and baggage procedure
- Inform brigade members about packing guidelines
- Be available to answer last minute questions
- Recruit volunteers to help with last minute packing
- Email tickets, and information about evacuation insurance
- Bring your team leader handbook, brigade lists, and cell phone numbers with you to airport
U.S. GLOBAL HEALTH POLICY

THE U.S. GOVERNMENT’S GLOBAL HEALTH POLICY ARCHITECTURE:
Structure, Programs, and Funding

EXECUTIVE SUMMARY

April 2009
THE U.S. GOVERNMENT’S GLOBAL HEALTH POLICY ARCHITECTURE:
Structure, Programs, and Funding

EXECUTIVE SUMMARY

April 2009

Jen Kates
Kaiser Family Foundation

Julie Fischer
Stimson Center

Eric Lief
Stimson Center
Acknowledgments

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In addition, much of the data used in this analysis were collected through a contract with the Stimson Center, under the direction of Julie Fischer and Eric Lief, with their colleague, Vidal Seegobin.

This report was supported in part by a grant from the Bill & Melinda Gates Foundation.
**Executive Summary**

The United States government has been engaged in international health activities for more than a century, beginning with efforts in the late 1800s to join with other nations to form the first international health organizations, standards, and treaties designed to promote growing international trade and travel while protecting borders from external disease threats. Since then, the U.S. engagement in global health has grown considerably, most markedly in the last decade, and today, the achievement of global health has become a stated U.S. policy goal. Multiple, interrelated factors have contributed to this growing engagement, including U.S. successes in identifying ways to eliminate and control many diseases at home and abroad, such as malaria and polio; growing globalization more generally; and the emergence of new infectious disease threats, most notably HIV, SARS, and avian influenza, shattering the belief that such threats were a thing of the past, and leading to increasingly explicit linkages being drawn between national security and global health, particularly in the post-9/11 era. Key features of the U.S. response are as follows:

**History, Scope, and Role:**

- The U.S. engagement in international health, initially sparked by economic as much as health concerns, has developed within two main structures of the U.S. government: the foreign assistance structure, which is predominantly development-oriented and has close links to foreign policy; and the public health structure, which has its roots in disease control and surveillance efforts. While these domains have very different purposes, cultures, and strategies, they have an increasingly linked history in responding to global health, although most funding for and oversight of global health resides within foreign assistance agencies and programs.

- The scope of the U.S. global health engagement is broad, and includes basic and essential health care services and infrastructure development; disease detection and response; population and maternal/child health; nutrition support through non-emergency food aid and dietary supplementation; clean water/sanitation promotion; and mitigation of environmental hazards.

- The U.S. role is multi-faceted, and includes acting as donor to low- and middle-income countries; engaging in global health diplomacy; providing technical assistance and expertise; operating programs; participating in international health organizations; leading world research and development efforts; and partnering with other government and non-governmental organizations.

**Funding:**

- U.S. funding for global health has increased significantly over time, particularly in the last decade; funding more than doubled between FY 2004 and FY 2008, reaching $9.6 billion in FY 2008. Still, funding for global health represents only a small fraction of the overall U.S. federal budget (as does foreign aid in general).

- Most funding for global health is provided through bilateral channels, and bilateral funding has grown as a share of the U.S. global health budget over time, accounting for 87% of funding in FY 2008. In addition, funding is primarily provided through the international affairs budget (86%) and through the State Department, which receives the largest share of the global health budget (51%), followed by USAID (28%) and the Department of Health and Human Services and its operating divisions (12%).

- While funding for all major global health sub-sectors (HIV, TB, malaria, maternal and child health, family planning, and water) increased between FY 2004 and FY 2008, funding for HIV drove most of the increase and accounted for the largest share of the budget (52% in FY 2008).

- The U.S. approach is best characterized as “vertical” (vs. horizontal), primarily focused on thematic objectives such as a disease or problem (e.g., PEPFAR, water, etc.), rather than more general support. In addition, most funding is provided to large scale-multi agency initiatives (73% of FY 2008 funding), rather than core support to agencies.

- The U.S. is the largest donor to global health efforts in the world, although when measured as a percentage of GDP, it does not rank as high as other donor governments.
The Administration and Congress

- The number of U.S. agencies involved in global health has increased over time. Today, there are seven executive branch departments, four independent, or quasi-independent, federal agencies, numerous departmental agencies/operating units, and several large-scale, multi-agency initiatives that together comprise the U.S. government’s global health “architecture.” See Figure 1.

U.S. agencies carry out global health activities in more than 100 countries throughout the world, although most programming is concentrated in a subset of countries that are either hardest hit by health problems (e.g., countries in sub-Saharan Africa hard hit by HIV), have the poorest economies (e.g., Haiti), and/or represent larger U.S. strategic interests (e.g., Afghanistan, Pakistan, China).

More than fifteen Congressional committees have jurisdiction and oversight over global health programs, particularly those that govern foreign assistance and, to a lesser extent, public health programs.

Despite the growing engagement of the U.S. government in global health, there is currently no formal, authoritative, coordinating mechanism for the U.S. response.

Additional figures from the full report follow.
FIGURE 2: U.S. Government Funding for Global Health as Share of Federal Budget, FY 2008

NOTES: Global health funding includes combined bilateral and multilateral funding for all U.S. global health sub-sectors.
SOURCE: Kaiser Family Foundation analysis of data from U.S. government agency published reports; SF-133 Reports on Budget Execution and Budgetary Resources; OMB Public Budget Database; OMB, Budget of the United States Government, Fiscal Year 2009, Historical Tables; direct data requests to agencies and OMB.


NOTE: Includes combined bilateral and multilateral funding for all U.S. global health sub-sectors.
SOURCE: Kaiser Family Foundation analysis of data from U.S. government agency published reports; SF-133 Reports on Budget Execution and Budgetary Resources; OMB Public Budget Database; direct data requests to agencies and OMB.
Executive Summary

The U.S. Government’s Global Health Policy Architecture: Structure, Programs, and Funding

![Graph 4: U.S. Government Global Health Funding by Department and Agency, FY 2008](image)

**Total = $9.6 billion**

- USAID: $2,722 million (28%)
- State – OGAC: $4,662 million (48%)
- Millennium Challenge Corp: $617 million (6%)
- CDC: $302 million (3%)
- USDA: $55 million (<1%)
- Peace Corps: $65 million (<1%)
- DoD: $95 million (1%)
- NIH: $831 million (9%)
- State – Other: $262 million (3%)
- Other*: $31 million (<1%)

**NOTES:** Includes combined bilateral and multilateral funding, for all U.S. global health sub-sectors. “Other” represents funding at HHS Office of Global Health Affairs, EPA, and DHS. State OGAC includes PEPFAR Global HIV/AIDS Account and part of the Global Fund appropriation. NIH includes part of the Global Fund appropriation. PEPFAR funding is also included in USAID, CDC, and NIH totals.

**SOURCE:** Kaiser Family Foundation analysis of data from U.S. government agency published reports; SF-133 Reports on Budget Execution and Budgetary Resources; OMB Public Budget Database; direct data requests to agencies and OMB.

![Graph 5: U.S. Government Funding for Global Health by Major Sub-Sector and for the Global Fund, FY 2008](image)

**Total = $9.6 billion**

- HIV/AIDS: $4,978 million (52%)
- Maternal & Child Health: $806 million (8%)
- TB: $162 million (5%)
- Malaria: $495 million (5%)
- Water: $738 million (8%)
- Family Planning & Repro Health: $467 million (5%)
- Global Fund*: $841 million (9%)
- Avian Flu: $115 million (1%)
- Other: $1,039 million (11%)

**NOTE:** U.S. contributions to the “Global Fund are part of PEPFAR, and are provided to the Global Fund without a specified disease allocation.

As such, they are included above as a stand-alone category. The Global Fund pools U.S. government and other donor contributions and provides grants to low- and middle-income countries for HIV, TB, and/or malaria activities. To date, the Global Fund reports distributing 62% of funding to HIV programs, 25% to malaria, and 14% to TB (see http://www.theglobalfund.org/en/distributionfunding/?lang=en#disease).

**SOURCE:** Kaiser Family Foundation analysis of data from U.S. government agency published reports; SF-133 Reports on Budget Execution and Budgetary Resources; OMB Public Budget Database; direct data requests to agencies and OMB.
Executive Summary

The U.S. Government's Global Health Policy Architecture: Structure, Programs, and Funding

NOTE: Does not necessarily reflect U.S. regional programming or U.S. assistance provided to multilateral organizations that may reach countries.

FIGURE 6:
Developing Countries with U.S. Government Global Health Programming or Personnel, FY 2007

NOTE: Does not necessarily reflect U.S. regional programming or U.S. assistance provided to multilateral organizations that may reach countries.

FIGURE 7:

NOTE: Represents bilateral assistance only and does not necessarily reflect U.S. regional program funding or U.S. assistance provided to multilateral organizations that in turn may be provided to countries.
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This report (#7881) is available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible information, research and analysis on health issues.
The many agendas prepared for the Obama administration constitute a consensus about the importance of—and need for improvement in—global health efforts.

The last few months have seen a bumper crop of “agendas” for the Obama administration on everything from climate change to education reform. In global health, some of the most influential American voices in development policy have advised the administration about where to focus U.S. global health efforts and how to spend aid for health effectively. The similarities across these missives are remarkable—they signify a level of technical consensus required for success.1 Read carefully, they show what many in the U.S. global health community are thinking about why global health is important, where improvements are needed, and what the future holds. Differences (and there are some) tend to center on technical details, framing, and money.

In this note, I compare the statements prepared by global health experts under the auspices of the National Intelligence Council (NIC) and the Institute of Medicine (IOM); the Center for Global Development (CGD), the Center for Strategic and International Studies (CSIS), and the Council on Foreign Relations (CFR); Interaction, the Global Health Council (GHC), and ONE (see table, page 5). In the commonalities, the administration and Congress can find state-of-the-art guidance about where to focus.

How Do We Justify U.S. Investments in Global Health?

Two rationales underlie the U.S. commitment to deploy financial and technical resources to address health problems in low- and middle-income countries. The first is variously described as a moral imperative, a humanitarian impulse, or altruism and generosity. The second is enlightened self-interest, including both protection from health (and corresponding economic) threats and the enhanced international reputation (and national security) resulting from the use of “soft power.”

The moral imperative

All of the global health agendas prepared for the Obama administration cite the moral imperative as a justification for U.S. investments—but not, as one might expect, with trumpets blaring. Instead it is mentioned rather hurriedly, quietly, almost in a whisper. Why? The global health community is sometimes reluctant to discuss the moral underpinnings of its work, and not without reason. For one, it is obvious (no one needs to be told that keeping people alive and healthy is the right thing to do, right?). In addition, pontificating about the transcendent dimension is a quick and effective way to annoy friends and alienate partners.

But there is another, more central reason experts shy away from justifying global health efforts on moral grounds: the real or potential tensions between passionate advocacy on the one hand, and reasoned scientific analysis on the other. Certainly these poles were sometimes at odds during the Bush administration, and part of the tenor of these documents reflects the community’s efforts to respond to a new ascendancy of “evidence-based policymaking.” Nevertheless, the

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1 A look at large scale global health successes of the past, shows that a convergence of views among those in the expert community about the right approach was always present. See Case Studies in Global Health: Millions Saved (Jones and Banerji, 2007).

This note was made possible by financial support from the Bill & Melinda Gates Foundation. The views expressed are those of the author and should not be attributed to the board of directors or funders of the Center for Global Development.
shared and essential impulse to respond to sickness and hunger and suffering is at the heart of each of these documents.

The “interests” argument

The authors of these global health agendas share a fundamental worldview that global interconnectedness means that the well-being of Americans is inextricably linked to the lives of people thousands of miles away. Touch one part of the spider web and you set the whole thing trembling. We should therefore invest in the health of others in part because it is in our interest.

The line of argument goes something like this: health interventions are highly visible, incurring large reputational benefits for the United States. Health interventions can thus improve the image of the United States, generate goodwill, win friends, and appease adversaries.2 These “hearts and minds” gains make Americans more secure. Some of the agendas take this argument further, saying that U.S. spending on global health interventions helps to fight terrorism.3 The NIC report adds that investing in infectious disease research, for example, keeps U.S. soldiers healthy, thus improving war-fighting capabilities.

Investing in health also makes good economic sense. Health interventions are among the most cost-effective tools to improve the lives of poor people in developing countries, providing good “bang for our buck.” They can even save us money in the long term: preventing infectious disease outbreaks, for example, can prevent economic losses in the United States that could reach as high as $100–$200 billion.4 The more ways we can think of to justify investments in global health (beyond the humanitarian concern), and the more closely we link it to the national interest, the more likely policymakers will support health interventions—right? But leaning too heavily on the “interests” argument has consequences. If improved health is about the narrow, short-term, and ever-changing political interests of the United States, then our health programs will probably be narrow, short-term, and ever-changing.

The Top Ten To-Do List

While the framing and language may differ, ten common strands cross all of the recent global health agendas.

1) Take the Lead

Maintaining support for current programs, particularly in hard economic times, and getting the greatest reputational benefit from them requires visible White House leadership. The president should highlight the importance of investing in global health early on in his presidency.

2) Coordinate

Improved coordination and coherence across the many U.S. agencies involved in global health is essential after a period of increased fragmentation. The Institute of Medicine and Center for Global Development call on the new administration to establish an interagency task force to increase coordination, preferably led by the White House, while the Center for Strategic and International Studies suggests establishing a Global Health Corporation.

3) Be Results-Driven

Health priorities should be established on the basis of achieving health gains most effectively rather than on short-term strategic or tactical U.S. interests. The United States should intensify efforts to measure program outcomes and achieve higher

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2 CFR’s Laurie Garrett and the National Intelligence Council both cite Cuba’s health interventions in Latin America and Hamas’s and Hezbollah’s efforts in the Occupied Territories and Lebanon (respectively) as examples of the power of health interventions to buy political support.
3 CSIS, GHC, CFR and NIC.
efficiencies in the use of current resources. Congress and the administration should require that aid be accompanied by rigorous country- and program-level evaluations to measure the impact of global health investments (such as deaths avoided or HIV infections prevented). This is particularly important for PEPFAR; prevention efforts, including abstinence only, should be subject to rigorous evaluation.

4) Ramp Up HIV Prevention

PEPFAR is widely regarded as a success of the Bush administration, and those in the global health community uniformly acknowledge its unprecedented level of funding and program performance. At the same time, there is agreement that the program must be cognizant of the fiscal burden associated with HIV treatment efforts and expand and improve the effectiveness of HIV prevention. While this is mentioned as a priority in all the documents, the Center for Global Development offers the most specific recommendations: maintaining funding for (and maximizing the success of) antiretroviral treatment is essential, but the number of PEPFAR focus countries should not be expanded. By 2012, the United States should aim to prevent 90 percent of annual infections in focus countries, and prevention efforts must be guided by what is proven scientifically to work. This includes expanding condom distribution and access to circumcision; integrating family planning services with HIV testing and AIDS treatment; reorienting HIV testing toward in-home services for couples rather than facility-based testing of individuals; and needle-exchange efforts where intravenous drug use is an important part of transmission dynamics.

5) Expand beyond AIDS and Malaria

The global health portfolio should be balanced in support of a wide range of health issues, including nutrition, disease surveillance, water and sanitation, child and women’s health, family planning and reproductive health, chronic and noncommunicable diseases, and—fundamental to success in all areas—health system strengthening. Even diseasespecific funding should contribute to health system and workforce strengthening. Several agendas call on the United States to commit to train local health care providers; others for more research to analyze, experiment, manage, and test health systems innovations. ONE recommends that the United States discuss donor coordination of health system strengthening at the 2009 G-8 Summit, and support the creation of a Global Health Care Partnership to coordinate efforts and fund national health system plans in at least 19 countries by 2010.

6) Respond to Country-Defined Objectives

Aid should be allocated and delivered in ways that recognize the importance of “country ownership.” Priority should be given to aligning U.S. aid priorities in health with the priorities of national governments and local stakeholders to avoid donor-driven interventions and ensure sustainability, ownership, and capacity building. Interaction recommends that, in at least 15 countries, the United States create a coordinated strategy in collaboration with governments and NGOs to meet identified health care needs.

7) Use Multilateral Channels

No single country has the resources to go it alone, and the lack of harmony hinders recipient countries and creates program duplication. The conclusion: multilateral cooperation is essential. Linkages should be strengthened between the United States, the European Union, the African Union, G-8 member states, and multilaterals. CGD recommends that the United States channel at least 50 percent of development assistance for health to multilateral institutions by 2012, and be an active and dues-paying member of the UN agencies involved in global health. The United States should support a careful, multinational, external review of the World Health Organization to ensure the organization—the world’s premier multilateral global health institution—

Multilateral cooperation is essential: no single country has the resources to go it alone; lack of harmony across programs hinders countries receiving health assistance.
The global health policy community in the United States has rarely been as united as it is now. The calls for a smarter, more harmonized, results-based global health agenda are clear.

8) Invest in Research

The United States should strengthen its leadership role in research and development, including by empowering the National Institutes of Health (NIH). The Fogarty International Center should analyze investments in global health at NIH and identify priority areas for spending. CGD recommends that Congress channel 10 percent of all AIDS research funding through the National Science Foundation to examine how HIV/AIDS prevention and treatment services can best be delivered in a manner that complements, rather than undermines, other locally needed health care services. Exchanges for training, research, and practice should be established and institutional partnerships with universities and other research organizations in developing countries strengthened.

9) Promote Service

ONE recommends doubling funding for the Peace Corps by 2011, and CGD recommends establishing a Global Health Corps to give American doctors and other health workers the opportunity to serve the poor of developing countries. Such efforts symbolize the spirit and values of U.S. foreign policy and are tangible demonstrations of the U.S. commitment to world peace and development.

10) Put Your Money Where Your Mouth Is

Most of these documents call for various increases but there is a pervasive sense, a recognition just beneath the surface, that increased funding levels are unlikely, given the global economic crisis and the relative growth of global health spending in recent years. Indeed, the emphasis on achieving measurable results reflects a desire to see efforts save lives and improve health, but also an understanding that as the budget is squeezed, programs will be more closely scrutinized. CGD and CSIS refrain from calling for funding increases.

The (Mostly) Unmentionables

The impressive level of agreement among the global health agendas sends a strong, clear signal. It also reflects a tactic of overlooking some potentially controversial topics in which the right answers are harder to come by and potentially more subject to diverging views. These include, for example, the extent to which PEPFAR should modify its goals with respect to AIDS treatment coverage; the wisdom of untying aid and moving away from dependence on a relatively small set of government contractors to implement global health programs; the role of faith-based organizations; the value of embracing the “alignment and harmonization” agenda promoted by many European donors; and the vulnerabilities associated with the significant influence of a single philanthropic entity, the Bill & Melinda Gates Foundation.

The Bottom Line

With key appointments still to be made and budget proposals and debates on the horizon, I don’t know how closely the future global health programs of the United States will conform to the vision set out by the close observers who have developed the recommendations discussed in this note. What we do know is that the global health policy community in the United States has rarely been as united as it now is about the challenges and opportunities facing the country and the world. At least at the level of big-picture agendas, the messages are clear.

When the responsible appointees are named in the State Department and the U.S. Agency for International Development, in PEPFAR and the President’s Malaria Initiative, in the Centers for Disease Control and Prevention, the National Institutes of Health, the Department of Health and Human Services, and the Department of Defense, they will—in every way—have their work cut out for them.
<table>
<thead>
<tr>
<th>A Summary of Global Health Agendas by Organization</th>
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<tbody>
<tr>
<td><strong>How is investment in global health justified?</strong></td>
</tr>
<tr>
<td>IOM: Institute of Medicine</td>
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<tr>
<td>GHC: Global Health Council</td>
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<tr>
<td>CSIS: Center for Strategic and International Studies</td>
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<tr>
<td>CFR: U.S. Department of State</td>
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<tr>
<td>NIC: National Intelligence Council</td>
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<tr>
<td>Interagency</td>
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<tr>
<td>GHC: Global Health Council</td>
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<tr>
<td>ONE: Economic</td>
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**Notes:**
- IOM: Institute of Medicine
- CGD: Center for Global Development
- CSIS: Center for Strategic and International Studies
- NIC: National Intelligence Council
- GHC: Global health Council
- n/a: not applicable
Further Reading


Public – private 'partnerships' in health – a global call to action

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Abstract
The need for public-private partnerships arose against the backdrop of inadequacies on the part of the public sector to provide public good on their own, in an efficient and effective manner, owing to lack of resources and management issues. These considerations led to the evolution of a range of interface arrangements that brought together organizations with the mandate to offer public good on one hand, and those that could facilitate this goal though the provision of resources, technical expertise or outreach, on the other. The former category includes of governments and intergovernmental agencies and the latter, the non-profit and for-profit private sector. Though such partnerships create a powerful mechanism for addressing difficult problems by leveraging on the strengths of different partners, they also package complex ethical and process-related challenges. The complex transnational nature of some of these partnership arrangements necessitates that they be guided by a set of global principles and norms. Participation of international agencies warrants that they be set within a comprehensive policy and operational framework within the organizational mandate and involvement of countries requires legislative authorization, within the framework of which, procedural and process related guidelines need to be developed. This paper outlines key ethical and procedural issues inherent to different types of public-private arrangements and issues a Global Call to Action.

Public-private partnerships in health – a global call to action
Public-private partnerships are being increasingly encouraged as part of the comprehensive development framework. The need to foster such arrangements is supported by a clear understanding of the public sectors inability to provide public goods entirely on their own, in an efficient, effective and equitable manner because of lack of resources and management issues. These considerations have necessitated the development of different interface arrangements, which involve the interfacing of organizations that have the mandate to offer public good on one hand, and those that could facilitate this goal.

Within the health sector, public-private partnerships are also the subject of intensely fueled debate [1]. Several examples, which fall within this framework, highlight a potential for the creation of a powerful mechanism for addressing difficult problems by leveraging on the strengths of different partners; however, these also illustrate complex issues, as such arrangements bring together a variety of players with different and sometimes
conflicting interests and objectives, working within different governance structures [2].

This paper focuses on public-private partnerships that are intended to address broad questions of providing sustainable health outcomes rather than on the day-to-day interaction that occurs when the government buys a health service from a private supplier or where it leaves the entire matter of health service supply to the private sector.

The public sector in this paper refers to national, provincial/state and district governments; municipal administrators, local government institutions, all other government and inter-governmental agencies with the mandate of delivering 'public goods'. The word private denotes two sets of structures; the for-profit private encompassing commercial enterprises of any size and the non-profit private referring to Non Governmental Organizations (NGOs), philanthropies and other not-for-profits. The word partnership in this paper refers to long term, task oriented, and formal relationships. There has been ample critique relating to the convention of using the word partnership to describe such arrangements; much of this debate is valid, given that there are certain requisites for coining such an association. For the same reasons it also needs to be differentiated from privatization, which involves permanent transfer of control through transfer of ownership right or an arrangement in which the public sector shareholder has waived its right to subscribe. A distinction also needs to be made between partnerships and contractual arrangements, particularly with regard to the relationship between the public sector and NGOs. Although such arrangements can be used for strategic purposes, they are inherently distinct from partnerships.

Types of public-private interface arrangements

The database of the Initiative on Public-Private Partnerships for Health of the Global Forum for Health Research lists 91 international partnership arrangements in the health sector, which can qualify to be called public-private partnerships. Of these, 76 are dedicated to infectious disease prevention and control, notably AIDS, tuberculosis and malaria; four focus on reproductive health issues, three on nutritional deficiencies whereas a minority focus on other issues (health policy and research {1}, injection and chemical safety {2}, digital divide {1}, blindness and cataract {4})[3]. This categorization takes into account large transnational public-private partnerships. There are, however, many other arrangements at a country level, which bring in their wake similar challenges as the ones posed by larger partnerships.

Several classifications have been proposed to conceptualize and categorize public-private partnerships. These may be based on the terms of the constituent membership or the nature of activity [4,5]. However by virtue of the definitions and the characteristics of the public and private sectors, it can be stated that public-private arrangements are fostered either when governments and inter-governmental agencies interface with the for-profit private sector to tap into resources, or the non-profit private sector for technical expertise or outreach. Several varieties of arrangements of various sizes, forms and scope at a global, regional or country level qualify to fall within this categorization. Transnational partnerships involving a visible role of the for-profit sector are at one end of the spectrum. These usually involve larger partnerships and a complex grouping; depending upon their structure, they may bring together several governments, local and international NGOs, research institutions and UN agencies in transnational programs, often also involving the non-profit sector. Such partnerships can be housed and coordinated by different sources [6]. They can be owned by the public sector and have private sector participants such as in the case of Global Alliance for Vaccines and Immunization (GAVI) [7], Roll Back Malaria (RBM) [8], Stop TB partnership (Stop TB) [9], Safe Injections Global Network (SIGN) [10], Global Polio Eradication Programme (PEI) [11], the Special Programme for Research and Training in Tropical Diseases (TDR) [12], and the Special Programme for Research Development and Research Training in Human Reproduction (HRP) [13]. Partnerships can be principally orchestrated by companies such as in the case of Action TB [14], and can be legally independent such as the International Aids Vaccine Initiative (IAVI) [15], Medicines for Malaria Venture (MMV) [16], Global Alliance for TB Drug Development (GATBDD) [17], and the Concept Foundation (CF) [18]. Large partnerships can also be hosted by a civil society NGO; examples include the Malaria Vaccine Initiative (MVI) [19], the Mectizan Donation Programme (MDP) [20], and the HIV Vaccine Initiative (HVI) [21].

At the other end of the spectrum, there are examples of individual governments forming partnerships with the for-profit private sector [22]. There are also examples of situations when a government partners with an NGO with a particular technical strength, technical or outreach related. The recent evolution of a public-private partnership for the prevention and control of non-communicable diseases in Pakistan is an example of this approach, where the government leverages on the technical strength of the private sector partner for addressing an emerging health challenge [23]. Examples also exist of NGOs seeking support from corporate partners both at a national and an international level. The World Heart Federation has recently structured transparent and successful business relationships with the corporate sector for supporting global programs with initial encouraging results [24,25].
Partnerships in the health sector can be for various purposes; categories as stated by the Initiative on Public-Private Partnerships for Health have been summarized in Table 1. Such partnerships are novel arrangements and potentially present an opportunity for more than one partner(s) to contribute to the same goal. Many of these have positively contributed to health outcomes in the past; developing technologies for tropical diseases, surveillance and screening strategies, contributing to technical aspects of sustainable drug development and vector control are amongst a few examples [26,27]. Notwithstanding, partnerships involving the for-profit private sector bring in their wake many concerns as they involve a donor-recipient relationship [28].

In many countries, there are long established links of the public sector with NGOs. Theoretically, since NGOs are not driven by a profit generating motive, many of the ethical challenges that potentially exist in partnering with the for-profit are not of relevance in this case. However, it could also plausibly be argued that NGOs, who though objective and altruistic, may, in fact, have quite complex motives. In promoting public-private partnerships therefore, several issues need to be clearly flagged in an attempt to address them in tandem with efforts that aim to foster such relationships. Within that context, a set of ethical and process related challenges are summarized hereunder:

Ethical challenges, which are largely generic across the range of public-private partnerships relate to the following dimensions

1. Global norms and principals: many of the large partnerships involving a variety of players are of a transnational nature. However, against this backdrop, there are no global norms and principals, to set a framework within which global public health goals can be pursued in a partnership arrangement.

2. Impartiality in health: if public-private partnerships are not carefully designed, there is a danger that they may reorient the mission of the public sector, interfere with organizational priorities, and weaken their capacity to uphold norms and regulations. Such a shift is likely to displace the focus from the marginalized and may therefore be in conflict with the fundamental concept of equity in health.

3. Social safety nets: it has been increasingly argued that engaging in a partnership mode provides the public sector an opportunity to renounce their responsibilities; this in a sense may lead to withdrawal of social safety nets. Failure to commit to maintain the role of the state in such partnerships may result in a laissez-faire attitude, prejudicial to the interest of the most vulnerable groups.

4. Conflict of interest: many partnerships are initiated on the premise that they fulfill a social obligation, and can involve good intentions on part of individuals and organizations. However the basic motive that drives the ‘for-profit’ sector demands that these involve a financial pay off in the long term. In such cases, the difference between corporate sponsorships and scientific philanthropic donations with long term visible public health goals needs to be clearly separated. This issue has been further complicated in recent years as many global health initiatives funded by endowments generated by foundations have partnerships with the private sector as a key feature [29]. Such donor-recipient relationships bring in their wake many concerns. These include concerns relating to such arrangements providing the ‘for profit’ private sector an opportunity to improve their organizational image by engaging in cause-related marketing and concerns relating to these engagements facilitating access of the commercial sector to policy makers. On the other hand, many NGOs even in the developing countries are

Table 1: Categorization of public-private partnerships based on the purpose they serve

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Partnership</th>
</tr>
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<tbody>
<tr>
<td>1 Product development</td>
<td>GATBDD, IAVI, MMV and MVI.</td>
</tr>
<tr>
<td>2 Improving access to healthcare</td>
<td>CF, MDP, Accelerated Access Initiative (AAI) [48], Global Alliance to Eliminate Leprosy (GAEL) [49], Global Alliance to Eliminate Lymphatic Filariasis (GAELF) [50] and the Global Polio Eradication Initiative (GPEI) [51].</td>
</tr>
<tr>
<td>3 Global coordination mechanisms</td>
<td>GAVI, RPS, Stop TB, Global Alliance for Improved Nutrition (GAIN) [52], and the Micronutrient Initiative (MI) [53].</td>
</tr>
<tr>
<td>4 Strengthening health services</td>
<td>Alliance for Health Policy and Systems Research (AHPSR) [54], Multilateral Initiative on Malaria (MIM) [55], African Comprehensive HIV/AIDS Partnerships (ACHAP) [56].</td>
</tr>
<tr>
<td>5 Public advocacy and education</td>
<td>Alliance for Microbicide Development (AMD) [57], African Malaria Partnership (AMP) [58], Global Business Coalition on HIV and AIDS (GBC) [59] and Corporate Council on Africa (CCA) [60].</td>
</tr>
<tr>
<td>6 Regulation and quality assurance</td>
<td>The International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH) [61], Pharmaceutical Security Institute (PSI) [62] and the Anti-Counterfeit Drug Initiatives [63].</td>
</tr>
</tbody>
</table>
focused on the developing world. However, among these, almost all the making process is usually not optimally accomplished. This has implications of varying degrees. Many a times, a participatory approach to the decision ‘partnership’ gives the impression of equality. However, in the case of governments interfacing with NGOs, the stronger partner, which is usually the Government generally tends to make the rules. On the other hand, in the case of relationships with the ‘for-profit’ private sector, there is the danger of the financially stronger partner influencing the public sectors decision making process on policies, regulatory and legislative matters, which have implications for their profit-making motive.

6. Fragmentation of the health system: partnerships generally tend to aim for short term high profile goals and tend to pick the lowest lying fruits. Partnerships do have the mandate and cannot be held accountable to synchronize their activities with emerging processes within countries aimed at developing their health systems. Therefore if they are instituted in countries with weak health systems they have the potential to fragment the healthcare system by instituting independent vertical programs. The changing global agenda around ‘vaccines’ helps to highlight many of these issues. Previously polices around vaccination were grounded in the general principal that promoted equitable access to few vaccines around the world. However new initiatives and their vertical systems have less of a focus on sustainability, may not contribute to strengthening of the health system and have the potential of redirecting national health policies, which focus on equitable care.

7. Contribution to common goals and objectives: it is common for partners to have different objectives while pursuing a relationship though it may be implicit that partnerships are contributing to common goals.

8. Lack of outcome orientation: many a times, partnerships exist in form and do not contribute to improvements in quality and efficiency.

Operational and process-related challenges in public private partnerships relate to the following dimensions

1. Legislative frameworks, polices and operational strategies: many developed countries have legislation to interface with the private sector. However new initiatives and their vertical systems have less of a focus on sustainability, may not contribute to strengthening of the health system and have the potential of redirecting national health policies, which focus on equitable care.

2. Participatory approach to decision making: the expression ‘partnership’ gives the impression of equality. However, many a times, a participatory approach to the decision making process is usually not optimally accomplished. This has implications of varying degrees. Almost all the large 91 transnational partnerships referred to earlier are focused on the developing world. However, among these, 85 have their secretariats in Europe and North America; the United States and Switzerland being the commonest host countries. Clearly this lack of proximity to the intended beneficiaries has a bearing on the manner in which the beneficiaries have a role in the decision making process. The decision-making process in a partnership may also be biased because of the stronger partners’ influence. At a county level and in the case of governments interfacing with NGOs, the stronger partner, which is usually the Government generally tends to make the rules. On the other hand, in the case of relationships with the ‘for-profit’ private sector, there is the danger of the financially stronger partner influencing the public sectors decision making process on policies, regulatory and legislative matters, which have implications for their profit-making motive.

3. Governance structures: workable partnerships require a well-defined governance structure to be established to allow for distribution of responsibilities to all the players. Public-private partnerships may run into problems because of ill-defined governance mechanisms. Recent evaluation of the RBM project while acknowledging the successes of the partnership in drawing global attention to the scale of the problem posed by Malaria has outlined serious governance-related issues. More recently, independent evaluation of the Global Stop TB partnership has also resulted in the issuance of detailed recommendations for improved governance.

4. Power Relationships: skewed power relationships are a major impediment to the development of successful relationships. Governments in developing countries usually tend to assume core responsibility of the joint initiative and take charge of the weaker partner. In case of NGOs with outreach-related strengths, this usually takes the form of a ‘contractual relationship’ without much regard to the participatory processes, which should be key to a public-private partnership arrangement. In case of relationships with NGOs with technical strength, there are issues relating to power relationships of a more serious nature with regard to who assumes the leadership role.

9. Criteria for selection: the criteria for selection are an important issue both from an ethical and process-related perspective as it raises the questions of competence and appropriateness. In many instances the public sector is vague about important issues related to screening potential corporate partners and those in the non-profit sector.

10. Sustainability: the question of long-term sustainability is often ignored in public-private partnerships. An analysis of the operation of GAVI has concluded that it overemphasizes high technology vaccines, lacks sustainability, relies too heavily on the private sector and consequently,
runs the risk of compounding health inequities in the poorest countries [35].

11. Accountability: many partnerships do not ensure that all players are held accountable for the delivery of efficient, effective and equitable services in a partnership arrangement. Often in public-private relationships it is unclear as to whom are these partnerships accountable to, according to what criteria, and who sets priorities? To hold partners accountable for their actions, it is imperative to have clear governance mechanisms and clarify partner’s rights and obligations. Clarity in such relationships is needed in order to avoid ambiguities that lead to break up of partnerships. A case in point is the recent breakup of GAEL with the exit of the International Association of Anti-leprosy [36].

The Call to Action

In the world we live today, global agendas are being increasingly shaped by the private sector. The ‘for-profit’ private sectors’ immense resources make it an irresistible partner for public health initiatives. These arrangements can also be mutually synergistic. Governments and international agencies can tap into additional resources to fully fill their mandate whereas the commercial sector can fulfill its social responsibility, for which it is increasingly challenged. Additionally, the recent SARS epidemic and bio-terrorist threats should help to make the private sector understand the value of investment in health for reasons beyond fulfilling their social obligations. Active involvement of the ‘non-profit’ sector and donor coordination in country goals is also being increasingly encouraged within comprehensive development frameworks; this approach is synchronous and in harmony with the Poverty Reduction Strategy Paper Framework [37].

The development and health actors have highlighted the need to harness the potential that exists in collaborating with the private sector to advance public health goals. This is also becoming increasingly essential as both the public and the private sector recognize their individual inabilities to address emerging public health issues that continue to be tabled on the international and within country policy agendas. Public-private partnerships therefore seem both, unavoidable and imperative. However in building such collaborations, certain measures must be taken at a global level to assist global partnerships and set a framework within which efforts at a country level can emanate.

As a first step, there is a need to develop a set of global norms and ethical principles; a broad-based agreement over these must be achieved. The transnational nature and global outlook of emerging partnerships necessitate that these stem from a broad-based international dialogue.

It is critical that the driving principles for such initiatives be rooted in ‘benefit to the society’ rather than ‘mutual benefit to the partners’ and should center on the concept of equity in health. Norms must stipulate that partnerships contribute to strengthening of social safety nets in disadvantaged settings and should be set within the context of ‘social responsibility’ as the idea is not meant for private funds to be put to public use nor to privatize public responsibilities.

Global principles must specify that partnerships should be in harmony with national health priorities; they should complement and not duplicate state initiatives and should be optimally integrated with national health systems without any conflict of interest. Norms must make it mandatory for all partners in a ‘partnership’ arrangement to contribute to common goals as a true partnership is one in which the partners, though having different motivation and values have a shared objective. Global norms must outline that partners be committed to making contributions, sharing risks and the decision making process. Principles should emphasize an outcome orientation. Development of a public-private partnership in itself should not be seen as an outcome, but a process and an output; it is important for partnerships not to just exist in form but to contribute to improvements in health outcomes.

It must be made binding for international agencies to develop transparent policy and procedural frameworks. Many international agencies have established guidelines on interacting with the private sector [38-45]. However there is a need for comprehensive policies and operational strategies, which are crucial to ensuring transparency and protecting public interest [46]. Inviting third party reviews and ensuring an open process for deliberations will help to ensure transparency and reflect that these processes are indeed being structured in public interest.

Global efforts should demand, encourage and assist the development of policy and legislative frameworks shaping public-private partnerships within countries [47]. However in the setting of developing countries, there is a need for international actors to guide these and for them to emanate within the framework of global norms and standards. Assisting with capacity development through donor coordination may be a necessary prerequisite to this approach. Legislative and policy frameworks within countries will help to legitimize public-private relationships, lend credence to this approach, help to foster an enabling environment and provide a mandate for the development of ethical guidelines to further direct these initiatives.
Within stipulated legislative and policy frameworks, support must be provided to developing countries to develop specific guidelines to steer such relationships. Guidelines can assist with the development of selection criteria and help specify roles of the public and the private sectors. They can also assist with the development of models that outline combined governance structures, clearly aimed at improved systems of governance. Guidelines must also articulate a clear policy on a participatory approach to the decision making process. In addition, they should assist with assigning responsibilities to various levels of Government and then hold people and institutions both within Governments and those in the private sector that partner with them accountable for their performance.

Though an evidence-based approach and ethical considerations must never be compromised in such endeavors and every effort should be made to ensure that goals are mutually compatible, guidelines also need to be flexible in order to accommodate each partner’s organizational requirements and integrity. Moreover they need to be pragmatic. The public sector needs to recognize the basic legitimacy of the private sector and the profit motive that drives it. It is also essential for the public sector to respect the organizational autonomy and priorities of the nonprofit sector. In this context, partnerships and contractual relationships need to be carefully differentiated.

Partnerships must also be the subject of noteworthy empirical research, which would enable a detailed assessment of the specific issues inherent to the various types of public-private partnership arrangements from an ethical and methodological perspective.

The impetus for driving global and national efforts in creating a transparent and conducive environment for public-private partnerships needs to come from the public sector. This raises the issue of capacity within countries; the gap needs to be bridged by assistance from UN agencies, which have the mandate of harnessing and coordinating support among a variety of players for global actions. However, the results of such actions will only be as good as Governments make them; weak and poorly informed Governments cannot remedy their own deficiencies by seeking to yolk the private sector to their own uncertain cart.

In conceptualizing a framework that assists with setting global norms and guidelines and within-country legislative actions, it needs to be recognized that the dynamics of public-private partnership arrangements are generic across social sector. It may therefore be useful to allow this commonality to prevail in initiating global and country-specific actions.

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Help For Honduras:
Neal Gorman of Lutheran Medical Center in Sunset Park tells what a recent medical mission to Central America meant to both the patients and the professionals.

DOCS ON MISSION OF MERCY TO HELP THE POOREST OF THE POOR:

Last week I had the distinct pleasure of participating in an emotional but very special medical mission to Tela, Honduras, with members of the New York Honduran Committee, nine co-workers from Lutheran HealthCare, and a mix of medical professionals from NYC.

Living in one of the poorest countries in the western hemisphere (second only to Haiti), Hondurans suffer from massive unemployment and very little access to health care. Routine injuries and illnesses that can be easily handled in the United States can be permanently debilitating and even life-threatening in Honduras.

This year and in year’s past, we saw emaciated babies who can’t breast-feed because of severe cleft palates, poorly treated broken limbs that developed infections and have become unusable, and children with clubfeet so deformed that walking is nearly impossible. We even saw a 13-year-old girl whose arm was shot off in a revenge shooting.

Their lives are so different from ours. Even the hour and a half trip back to the San Pedro Sula airport was eye-opening.

The main highway is a narrow two-lane road riddled with hazards of all kinds: dead horses, bridges that have washed away, weather-worn men herding hungry-looking cattle on foot, children (as young as seven) begging for money or food and looking for work chopping grass with dangerously sharp machetes. Meanwhile, thirty-year-old Datsuns, pickup trucks and yellow school busses – fully packed with passengers and the occasional cow – are precariously passing each other on the wrong side of the road like it was Death Race 2000. We prayed a lot on the roads in Honduras.

Our medical brigade, made up of surgeons, nurses, technicians and a casting expert examined more than 220 patients and performed 16 surgeries. We provided medications and reconstructive surgeries and gave away bags of candy and toys to families waiting to be seen by the physicians.

We spent the first few days examining children and adults to see what conditions they needed treated.

As each day brought a new set of hopeful faces, doctors would operate on more and more patients. From clubfeet to gall bladder surgeries to setting or revising bone fractures, the team saw as many people as possible.
Lutheran Medical Center – Add One

A surprise highlight this year was Dr. Melissa Inniss, a bilingual speech/language pathologist and audiologist from the Center for Child Development at Lutheran Family Health Centers. She examined more than 50 patients suffering from a host of hearing and speech problems. Dr. Inniss was bombarded with patients anxious to see her. When members of the surgical and triage teams were wrapping up to go home she was not willing to leave until she had seen everyone that showed up that day.

Like the rest of us, Dr. Inniss contacted companies and friends for donations prior to the trip. We knew she was given six hearing aids but we were not prepared for the day she would fit six deaf patients with these much needed devices.

One patient in particular stands out. Her name was Bianca and she was born deaf. In a cramped, sweltering exam room, Bianca was fitted with her new aid, and we suddenly realized what we were witnessing.

She was hearing voices and sounds for the first time. To be part of that experience was spectacular and seeing her face light up with unbridle excitement was beyond description. There wasn’t a dry eye in the room.

The most enjoyable part of the trip was seeing patients treated in prior years. They came back to say hello and show us how well they were doing.

We made our home in Honduras for only a week, but the experience will last a lifetime. It is impossible to put in words how you feel doing this kind of work.

I asked one of our operating room nurses what she thought of the trip. She’s often swamped with paperwork and management issues in her day job.

In Honduras however, she worked directly with patients and witnessed even more amazing things than I did. She said simply: “It was heaven. That’s why I became a nurse. To help people.”

Neal Gorman is director of public relations at Lutheran Medical Center in Sunset Park.

For more information, to make a contribution, or to find out how you can make a difference, contact the New York Honduran Committee at 718-693-1137.
BRIEF INFORMATION ON A PARTNERSHIP FOR DEVELOPMENT BETWEEN THE PERMANENT MISSION OF DOMINICAN REPUBLIC TO THE UNITED NATIONS, SAMANA COLLEGE RESEARCH CENTER, JEWISH RENAISSANCE FOUNDATION AND MEDICAL CENTER

Dr. ALAN GOLDSMITH
PRESIDENT
JEWISH RENAISSANCE FOUNDATION
JEWISH RENAISSANCE MEDICAL CENTER

The Jewish Renaissance Foundation (JRF) and the Jewish Renaissance Medical Center (JRMC) would like to offer its services in an effort to assist your country as it continues to respond to the devastation wrought by Hurricane Noel. We seek to collaborate with you, your governmental officials, and your medical community in a cooperative medical mission to assess and address the storm’s consequences as they relate to the health and well-being of your people.

JRF & JRMC proposes to undertake the three to four-day mission during the first week of December. With your guidance and assistance, our medical team would first meet with government officials, in order to glean their assessment of health needs. We would then move to the medical facility closest to the areas determined to have the most need and plan to set up a staging area for our equipment and supplies for coming visits. Members of your medical community would then be engaged in in-depth discussion to gain their insight on the health care and support requirements of their patients and the general population. Based on the discussions, our staff would then work with the designated governmental and health representative to develop plans of action addressing short-term needs, seeking to stabilize and improve immediate concerns, as well as long-term needs. Our ultimate goal is to enable a process that will provide for proactive responses, anticipating those future needs and providing for relationships and materials to meet them. Once the plans are found agreeable, we will utilize our resources to leverage funds for implementation.

JRF & JRMC awaits your guidance as to further action on our part. Godspeed in your efforts.