would be "switched off" by the gonadotrophin releasing hormone analogues used during in vitro fertilisation and the high levels of oestradiol. Acupuncture may act by reducing the contractility of the uterus and thereby avoiding expulsion of embryos after transfer or through unknown effects on the blood flow to the endometrium.[6] Animal and human studies investigating the effect of acupuncture through a direct or indirect mechanism on the uterus or the endometrium are needed.

National guidelines and recommendations should be based on systematic reviews and meta-analyses. Should adjuvant acupuncture now be included in national guidelines such as the National Institute for Health and Clinical Excellence guidelines from the British Fertility Society?[7] We think that it is too early for such a recommendation. Publication bias may have influenced the results of the meta-analysis. A Danish randomised controlled trial on adjuvant acupuncture that includes more than 600 women having in vitro fertilisation (twice as many as in the largest randomised controlled trial included in the meta-analysis) is currently under way. Before adding adjuvant acupuncture for in vitro fertilisation to any national guideline we must wait for the results of this and other studies to clarify the value of this treatment.

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Funding for primary health care in developing countries

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

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

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

An example of vertical programming is the enormous donor response to the HIV epidemic. In 2006, although Zambia's entire Ministry of Health budget was only $136m, the President's Emergency Plan for AIDS Relief provided the country with an HIV targeted budget of $150m. This unbalanced distribution of health funding occurs across sub-Saharan Africa. Thus, although HIV positive patients receive free care, others with more routine diseases receive poor care and still have to pay. Salaries of healthcare providers working for donor funded vertical programmes are often more than double those of equally trained government workers in the fragile public health sector. This lures government workers to the higher paying vertical programmes and creates an internal "brain drain." But it is the underfunded primary care clinics and health centres that care for all diseases, including common illnesses such as diarrhoea, malnutrition, and respiratory tract infections, which take many more lives than HIV, tuberculosis, and malaria.

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

be prevented and treated in a systematic way.

This campaign is not acting in a vacuum. A broad approach—orienting funds to governments for comprehensive provision of care—is being implemented in several countries in sub-Saharan Africa. The Global Fund to fight AIDS, Tuberculosis, and Malaria has called for investment to strengthen health systems and tackle social determinants by supporting strategies to reduce poverty.[7] The United Kingdom's prime minister, Gordon Brown, in a joint statement with Germany's chancellor, Angela Merkel, announced the launch of the "International Health Partnership."[8] The core idea is to encourage low income countries to create comprehensive country-wide health programmes, which would serve as the basis for all foreign assistance for health. Hopefully, other donors will follow these leads.

How would 15by2015 work? Take the example of Mozambique. In 2005, the total health expenditure in the country was $356m. Foreign assistance accounted for $243m, from which $130m was channelled through disease specific vertical funds managed directly by donors.[9] We propose that, 15% of the vertical funds from donor organisations (in this example, $19.5m) should be diverted into the government's common health fund and be earmarked for strengthening primary health care through improvement of infrastructure, health education, and investment in human resources. This amount of money could support 65 health centres for a year. These centres could be staffed by primary care teams including family doctors, mid-level care workers, primary care nurses, pharmacists, and health promoters. If one primary healthcare centre covers a population of 20 000 people, then 65 health centres would give 1.3 million people access to improved primary health care.

Part of the 15by2015 fund could be allocated to support the training and upgrading of skills. It could also be used to provide better pay for health personnel to encourage them to stay in areas where they are needed and to pay for community health workers, mid-level care workers, and "African family physicians" who are a fledgling but emerging force.[10 11] The Ministry of Health should monitor the accessibility and quality of this care in a transparent way to ensure that the 15by2015 fund is used most effectively to improve community health.

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Assessing the ability to work

New UK test claims to be fair but lacks rigorous scientific evaluation

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Recently, the Department of Work and Pensions in the United Kingdom announced a renewal of the personal capacity assessment. The report states that the renewal is expected to result in 20 000 fewer people claiming sickness benefits each year. It also claims that the new test is more robust, accurate, and fair than the previous one.[1]

Two issues are at stake here: firstly, the provision of work and a decent income for millions of people with disabilities and, secondly, the billions of pounds that society is willing and able to pay in disability benefits. In many European countries, the growing numbers of people claiming disability benefit and expenditure on these benefits is an important point of political interest.[2]

The personal capacity assessment lists 17 activities, each of which can be given a score according to the degree of limitation. People with a score of 15 or more are assessed as unable to work. Changes have been made to the 17 activities and limitations in the new assessment; for example, not being able to walk more than 30 metres had the highest disability score in the old assessment but this has been changed to 50 metres in the new one. Other changes make it more difficult to reach the highest level of work disability.

It is generally agreed that the World Health Organization (WHO) model of functioning provides the best framework for the evaluation of disability.[3] The basis of this model is that disability has three major components apart from having a disease: impairments in bodily or mental functions or structures, limitations in activities, and restrictions in participation in societal roles. Personal and environmental factors also play a role.

It is important for doctors to understand the essential difference between having a disease and having a disability.[4] The ability to work depends on balancing the limitations in activities with the demands that participation in working life imposes. The personal capacity assessment does reflect the WHO model in that the