

In Africa, Porter Sees Lessons for Health Care

It's no surprise to find HBS professor Michael Porter meeting with powerful people who seek his ear and prize his advice. But on a hot summer day at a remote rural hospital in the highlands of east Africa, it is HIV and TB patients to whom Porter listens intently as they describe their care and treatment. It's July 2007, and Porter is on a fact-finding trip to Rwanda, part of his work for the Global Health Delivery Project (GHD), a multifaceted collaboration involving researchers and professors from HBS, Harvard Medical School (HMS), and other Harvard schools.



PORTER WITH RWANDA'S PRESIDENT PAUL KAGAME: Beyond best practices, understanding principles of global health-care delivery. Photo by Susan Yong

In 1994, in about 100 days of internecine violence, some 800,000 of Rwanda's 9 million people were murdered, 1 million were internally displaced, and another 2 million fled their homeland. Yet today, just fourteen years later, Rwanda is looked to as a model for the rest of Africa, not the least for its successes with public health and health-care delivery.

The goal of the Global Health Delivery Project is to make the first-ever systematic study of global health-care delivery systems, "going beyond best practices to understand *principles*," Porter has said. As part of that effort, and emerging from his trip, Porter and several GHD colleagues have written a case study, "HIV Care in Rwanda," that was the subject of a special seminar at HBS in April attended by more than 85 students and faculty from HBS, HMS, and Harvard's School of Public Health. Two case protagonists were in attendance: Dr. Paul Farmer, an HMS professor and the subject of the best-seller *Mountains Beyond Mountains*, and Dr. Agnes Binagwaho, executive secretary of the Rwandan National AIDS Control Commission and a visiting lecturer at HMS. It was Binagwaho who, in 2005, invited Farmer and his grassroots medical organization, Partners In Health (PIH), to work in her country, based on PIH's success in Haiti.

The Rwanda case discussion was led by one of its authors, former WHO official and HMS professor Dr. Jim Yong Kim, a codirector and mainstay of the GHD (and, with Farmer, a PIH cofounder). Building on Kim's case presentation, Porter next outlined an emerging framework, growing out of the GHD's work, for health-care delivery in resource-poor settings. He observed that certain failings are shared by the health-care delivery systems of both developing and advanced countries: fragmentation, inefficiency, and organization around discrete interventions (such as delivering drugs or screening) rather than integrated care. Porter and his colleagues aim to shift thinking in global health-care delivery away from access to treatments and toward value for patients; he defined "value" as "health outcomes per dollar spent." Instead of the current

system of disjointed, episodic medical interventions, Porter argued for an integrated model that addresses the “full cycle of care” for patients. “The best way to contain costs is to improve quality,” he said, “because better health is cheaper than bad health.” This new model, he noted, takes into account obstacles to care that are present in developing countries, such as poor transportation, and also harnesses the role of the health-care system in catalyzing local economic development.

Binagwaho explained that rolling back disease by fighting poverty — and vice versa — is at the core of public-health policy in Rwanda; sweeping government legislation specifically supports and enhances that broad approach. And at the grassroots level, the Rwandan system is built around an integrated care model. For example, *accompagneurs*, community healthworkers who make frequent home visits to administer drugs and check on individuals with HIV and TB, ensure timely diagnosis and adherence to therapy. This both improves health outcomes and substantially lowers the overall cost of care.

Farmer said that he has learned from his work in very poor countries that “comprehensive rural health care must go beyond the purely clinical by also providing socioeconomic support. Nutrition, for example, is an essential element of any successful health-care delivery service.”

In part because it is a small, well-managed country and in part because it is in effect starting from scratch, Rwanda is achieving good results. Said Porter, “I’m optimistic that the world community is willing to provide outside resources for health care in poor countries, but only if health-care systems are designed and implemented on value principles. Beyond good intentions, we need to deliver results.”

For its part, through a combination of foreign aid and its own resources, Rwanda hopes by 2011 to have a fully funded service of basic health care covering the entire country. At a projected price tag of a mere \$200 million, that could teach the rest of the world some eye-opening lessons about value per health-dollar spent.

Visit the Global Health Delivery Project at www.hbs.edu/rhc/global_health.html.