



REACTOR PANEL:

Bridging the U.S. Experience to the Realities of Low- and Middle-Income Countries

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The reactor panel reflected on the day's presentations and highlighted a number of themes and ideas that could inform various audiences working to improve primary care across the globe.

Issues of Governance

Several presentations throughout the day emphasized community governance of, and participation in, the systems in which they receive care. Panelists considered how some of the approaches might be applicable in developing nations.

Dr. Wang commented that despite the frequently repeated assertion that the U.S. doesn't have a primary healthcare system, he concluded that in fact such a system does exist. However, in contrast to the systems in many developing countries, which are highly centralized and structured, the U.S. has a very decentralized system. In the U.S. there are data and monitoring systems that include large groups of providers, and planning systems that reflect the diversity of the delivery sector. Symposium presentations described a number of settings in which system governance is closely connected with the community being served, including direct participation of patients in governance structures. The models presented demonstrated that it is possible for a decentralized system to be stronger than the centralized but dysfunctional systems in some low-income countries.

Ms. De observed that the term "customer owner" echoed throughout the day's discussion. In contrast to the models in which communities drive the priorities of their systems based on local priorities, in many countries external donors drive how and to whom services are delivered. Donor funding is often earmarked for specific conditions, such as HIV/AIDS or malaria, rather than strengthening the primary healthcare delivery system as a whole. Thus, healthcare system flow and design is piecemeal, based on the priorities of the funder. The idea of having customers, and systems designed to benefit the customer, is not an approach that is used in most low-income settings. We don't hear about patient-centered design.

In many developing nations, Dr. Kress noted, healthcare is provided either by an inefficient government sector that is decidedly not customer-focused, or by a chaotic private sector that does not have a community orientation. He speculated that mission-based organizations, such as those hosted by various religious communities in East and West Africa, might be able to integrate some of the approaches of the Federally Qualified Health Center (FQHC) program. If implemented, their examples might serve as a wedge to stimulate innovation in other primary care models within the same countries. A challenge in many low-income nations is that you need to disrupt the existing systems profoundly, or drive a much higher level of competition, to create innovation for better care and better outcomes.

Financing Systems

Dr. Wang observed that while FQHCs are not government organizations, they receive funding from the government on the condition they provide good quality care. That is not the model prevalent today in most developing countries, where healthcare is either both financed and operated by the government, or by private sector organizations, neither regulated nor financed by government. The alignment of public and private sector payers and providers described in some of today's presentations often doesn't exist.

Ms. Scott described a frequent problem with financing in low-income countries, where donors often come with their own "dance cards," including their own rules and reporting systems. A key barrier to making financing more rational is a lack of imagination. The Primary Health Care Performance Initiative (PHCPI) currently represents a promising opportunity to help donors and ministries of health in low-income countries reimagine delivery system design. You can't accomplish what you can't imagine. With respect to the system-level focus of the PHCPI, the missing piece is alignment with the vertical, condition-specific priorities of the donor landscape. In the U.S. there is, to some extent, alignment of policy priorities even in a public and private sector multi-payer environment. In the developing world, such alignment is rare. Ms. Scott reiterated that it is critical to engage donors to set aspirations for overall primary healthcare improvement. Speakers at the symposium described several iconic technologies, such as Project ECHO, that are effective, scalable and can be rapidly deployed. Project ECHO and other delivery system innovations and ideas that have been successful in the U.S. multi-payer environment can still be deployed in countries with very different financing mechanisms.

Leadership

What kind of leadership is necessary to make transformation possible? Dr. Arora commented that his efforts to introduce Project ECHO in new countries were universally unsuccessful when he began by approaching senior government leaders. Although such leaders often expressed interest in the model, their interest was not followed by action. Therefore, he sought clinical champions on the ground who were willing to host ECHO implementation. Leaders became engaged only after seeing a successful, in-country implementation of the model. Additionally, establishment of ECHO programs often resulted in an increased sense of accountability and self-efficacy among providers, leading to improvements in provider availability at service sites.

Ms. De added that while some countries have strong health sector leaders, others do not. When donors and outsiders attempt to fill the gap, sometimes even more chaos is created. The concept of overall population health is not part of the usual discourse among donors in many low-income countries because donors are focused on their own narrow condition-specific priorities. Some of the relevant learnings from the day—concepts such as population health, whole person engagement, and multidisciplinary primary care teams—need wide dissemination among the donor community, and should be infused into the donor lexicon.

Care Delivery

Throughout the day, presenters shared important elements of system improvement: healthcare teams, integration of patients into care redesign, measurement- and improvement-focused organizational cultures, appropriate technology support, and methods of disseminating innovations. Dr. Massoud identified a key theme expressed by several presenters: the importance of recognizing the emotional responses evoked by many of the system changes, and the changes needed in relationships among individuals. Such changes require time to implement, and cannot be seen simply through the lens of efficiency. Using the example of a Gates Foundation-funded project in Ghana, Ms. Scott reinforced the fact that culture change in clinics in low-income countries does not require technology heavy innovation. Rather, substantial improvements arise from continuous implementation of techniques such as rapid cycle tests of change using plan-do-check-act methods, and low technology measurement techniques.

Dr. Wang suggested that the concept of team-based care is an attractive way to overcome unfavorable perceptions of, and low trust in, primary healthcare in low-income countries. The successful examples presented during the symposium showed improved outcomes and engagement when every patient has a team. If this is something that a low-income country can learn, it could build trust in and utilization of primary care. Ms. De acknowledged that the transformation to team-based care and integration of services is likely to require considerable effort in many settings that are currently designed around separate vertical programs. Integration and increasing scope of services will often require retraining, addition of staff, and additional funding.

Audience members offered comments suggesting that as community engagement and control of health systems increase, they are less likely to accept donor funding for projects or services that are not aligned with community priorities and approaches. Ms. Scott indicated that several more progressive low-income countries are already beginning to reject donor funding when it is not aligned with their priorities. One approach that has been successful in the U.S. is to include funders with interests in specific diseases or conditions as partners in the planning and execution of broader collaborative improvement efforts, such as the Health Disparities Collaboratives described earlier by Dr. Stevens.

Leveraging Technology

Several presentations focused on leveraging technology to support primary care delivery. The widespread use of mobile technologies in low income countries suggests that such technology provides an opportunity for significant innovation. Ms. Scott cautioned that it is critical for the technology to be connected to solutions to real problems. While technology can be profoundly transformative, it must be supported with training and a shared vision of how it can result in better outcomes. In their absence, there will continue to be developing countries with supply shelves full of unused iPads or mobile phones loaded with apps that have little real impact on the healthcare problems they are intended to address. Technology must be used in service of a broader strategy, with a whole systems approach. Dr. Wang concurred that health systems need to be ready to use technology, and that adequate human resources and infrastructure need to be in place before technology is introduced. Ms. De added that even innovative technology and data systems that support specific, time-limited projects often lie dormant



after the projects are completed unless they are connected to more comprehensive system transformations.

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